Well Child Visit Priorities and Anticipatory Guidance

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For each well child visit, tools are available to elicit parent concerns, document the visit, guide the administration of universal and selective screenings, and complement anticipatory guidance provided during the visit. Many such tools from the Bright Futures
Tool and Resource Kit are linked in this appendix. These are available for download for review and reference purposes only. To incorporate forms into an Electronic Medical Record System or to make multiple copies of specific items, a complete Tool and Resource Kit is available for purchase from the AAP Bookstore. Providers are not required to purchase these tools.

HFS' recommendations for minimal area(s) to be addressed are included in the text to follow. There are some areas that should be assessed initially and then visited only periodically or if the family has moved or otherwise changed.

At Every Visit

Providers should:

- Elicit the concerns of the parent(s)/caregiver(s) and the child when ageappropriate
- Conduct health supervision, including taking a comprehensive health history, observing parent-child interaction, conducting an unclothed physical exam, and administering appropriate immunizations and screening tests
- Provide anticipatory guidance and health education
- Consider opportunities to refer to available community resources, such as WIC, Family Case Management (FCM), Early Head Start/Head Start, Home Visiting, Part C Early Intervention (EI), Part B Special Education (via schools), etc.

Prenatal Visit: Priorities for the Visit

- Family resources (family support systems, transition home [assistance after discharge], family resources, use of community resources)
- Parental (maternal) well-being (physical, mental, and oral health; nutritional status; medication use; pregnancy risks)

- Breastfeeding decision (breastfeeding plans, breastfeeding concerns [past experiences, prescription or nonprescription medications/drugs, family support of breastfeeding], breastfeeding support systems, financial resources for infant feeding)
- Safety (car safety seats, pets, alcohol/substance use [fetal effects, driving], environmental health risks [smoking, lead, mold], guns, fire/burns [water heater setting, smoke detectors], carbon monoxide detectors/alarms)
- Newborn care (introduction to the practice, illness prevention, sleep [back to sleep, crib safety, sleep location], newborn health risks [hand washing, outings])

Newborn Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family readiness (family support, maternal wellness, transition, sibling relationships, family resources)
- Infant behaviors (infant capabilities, parent-child relationship, sleep [location, position, crib safety], sleep/wake states [calming])
- Feeding (feeding initiation, hunger/satiation cues, hydration/jaundice, feeding strategies [holding, burping], feeding guidance [breastfeeding, formula])
- Safety (car safety seats, tobacco smoke, falls, home safety [review of priority items if no prenatal visit was conducted])
- Routine baby care (infant supplies, skin care, illness prevention, introduction to practice/early intervention referrals)

First Week Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Parental (maternal) well-being (health and depression, family stress, uninvited advice, parent roles)
- Newborn transition (daily routines, sleep [location, position, crib safety], state modulation [calming], parent-child relationship, early developmental referrals)
- Nutritional adequacy (feeding success [weight gain], feeding strategies [holding, burping], hydration/jaundice, hunger/satiation cues, feeding guidance [breastfeeding, formula])
- Safety (car safety seats, tobacco smoke, hot liquids [water temperature])
- Newborn care (when to call [temperature taking], emergency readiness [CPR], illness prevention [hand washing, outings], skin care [sun exposure])

Anticipatory Guidance

- Newborn transition
 - Back to sleep
 - Daily routines
 - Calming techniques
- Newborn care
 - Emergency preparedness plan

- Frequent hand washing
- Avoid direct sun exposure
- Expect 6–8 wet diapers/day
- Nutritional adequacy
 - Breastfeeding (vitamin D supplement)

- Iron-fortified formula (if not breastfed)
- No solid foods
- No honey
- Parental well-being
 - Baby blues
 - Accept help
 - Sleep when baby sleeps
 - Unwanted advice
- Safety

- Car safety seat
- Smoke-free environment
- No shaking
- Burns (water heater)
- Smoke detectors
- Crib safety

Providers should **consider using tools to elicit parent concerns**, such as:

<u>Bright Futures Pre-visit Questionnaire – 2 to 5 Day (1 Week) Visit</u>

Bright Futures Parent Supplemental Questionnaire – 2 to 5 Day (1 Week) Visit

Providers may also wish to use the <u>Visit Documentation Form – 2 to 5 Day (1 Week)</u>
<u>Visit</u> to record elements of the health supervision visit. Providers should also use

patient/parent education materials that can be used to complement guidance
provided during the visit and/or highlight important areas that are not able to be
addressed, such as the <u>Bright Futures Parent Handout – 2 to 5 Day (First Week) Visit</u>.

One Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Parental (maternal) well-being (health [maternal postpartum checkup, depression, substance abuse], return to work/school [breastfeeding plans, child care])
- Family adjustment (family resources, family support, parent roles, domestic violence, community resources)
- Infant adjustment (sleep/wake schedule, sleep position [back to sleep, location, crib safety], state modulation [crying, consoling, shaken baby], developmental changes [bored baby, tummy time], early developmental referrals)
- Feeding routines (feeding frequency [growth spurts], feeding choices [types of foods/fluids], hunger cues, feeding strategies [holding, burping], pacifier use [cleanliness], feeding guidance [breast feeding, formula])
- Safety (car safety seats, toys with loops and strings, falls, tobacco smoke)

Anticipatory Guidance

- Infant adjustment
 - Tummy time
 - Encourage daily routines
 - Back to sleep
 - Sleep location
 - Techniques to calm

- Feeding Routines
 - Breastfeeding (400 IU vitamin D supplement)
 - Iron-fortified formula
 - Solid foods (wait until 4–6 months)
 - Elimination (5–8 wet diapers, 3–4 stools)
- Parental well-being
- Family adjustment
- Safety
 - Car safety seat
 - Falls
 - No strings around neck
 - No shaking
 - Smoke-free environment

<u>Bright Futures Pre-visit Questionnaire – 1 Month Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 1 Month Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 1 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 1 Month Visit</u>.

Two Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Parental (maternal) well-being (health [maternal postpartum checkup and resumption of activities, depression], parent roles and responsibilities, family support, sibling relationships)
- Infant behavior (parent-child relationship, daily routines, sleep [location, position, crib safety], developmental changes, physical activity [tummy time, rolling over, diminishing newborn reflexes], communication and calming)
- Infant-family synchrony (parent-infant separation [return to work/school], child care)
- Nutritional adequacy (feeding routine, feeding choices [delaying complementary foods, herbs/vitamins/supplements], hunger/satiation cues, feeding strategies [holding, burping], feeding guidance [breastfeeding, formula])
- Safety (car safety seats, water temperature [hot liquids], choking, tobacco smoke, drowning, falls [rolling over])

Anticipatory Guidance

- Nutritional adequacy
 - Breastfeeding (400 IU vitamin D supplement)

- Iron-fortified formula
- Solid foods (wait until 4–6 months)

- Elimination
- No bottle in bed
- Infant behavior
 - Calming skills
 - Physical (tummy time, daily routines)
 - Sleep (back to sleep)
- Parental (maternal) well-being
- Infant-family synchrony
- Safety
 - Car safety seat

- Falls
- Burns (hot liquids, water heater)
- Smoke-free environment
- Drowning
- Choking (small objects, plastic bags)

Bright Futures Pre-visit Questionnaire – 2 Month Visit
Bright Futures Parent Supplemental Questionnaire – 2 Month Visit

Providers may also wish to use the <u>Visit Documentation Form – 2 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 2 Month Visit</u>.

Four Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family functioning (parent roles/responsibilities, parental responses to infant, child care providers [number, quality])
- Infant development (consistent daily routines, sleep [crib safety, sleep location], parent-child relationship [play, tummy time], infant self-regulation [social development, infant self-calming])
- Nutrition adequacy and growth (feeding success, weight gain, feeding choices [complementary foods, food allergies], feeding guidance [breastfeeding, formula])
- Oral health (maternal oral health care, use of clean pacifier, teething/drooling, avoidance of bottle in bed)
- Safety (car safety seats, falls, walkers, lead poisoning, drowning, water temperature [hot liquids], burns, choking)

Anticipatory Guidance

- Family functioning
- Nutritional adequacy and growth
 - Breastfeeding (vitamin D, iron supplement)
 - Iron-fortified formula
 - Solid foods (when and how to add)

- Weight gain and growth spurts
- Elimination
- Oral health
 - Don't share utensils/pacifier
 - Avoid bottle in bed

- Safety
 - Car safety seat
 - Burns (hot liquids, water heater)
 - Falls
 - Walkers
 - Choking
 - Drowning
 - Lead poisoning

- Infant development
 - Social development
 - Communication skills
 - Physical (tummy time)
 - Daily routines
 - Sleep

<u>Bright Futures Pre-visit Questionnaire – 4 Month Visit</u> Bright Futures Parent Supplemental Questionnaire – 4 Month Visit

Providers may also wish to use the <u>Visit Documentation Form – 4 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 4 Month Visit</u>.

Six Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family functioning (balancing parent roles [health care decision making, parent support systems], child care)
- Infant development (parent expectations [parents as teachers], infant developmental changes [cognitive development/learning, playtime], communication [babbling, reciprocal activities, early intervention], emerging infant independence [infant self-regulation/behavior management], sleep routine [selfcalming/putting self to sleep, crib safety])
- Nutrition and feeding: adequacy/growth (feeding strategies [quantity, limits, location, responsibilities] feeding choices [complementary foods, choices of fluids/juice], feeding guidance [breastfeeding, formula])
- Oral health (fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed)
- Safety (car safety seats, burns [hot water/hot surfaces], falls [gates at stairs and no walkers], choking, poisoning, drowning)

Anticipatory Guidance

- Family functioning
- Nutrition and feeding
 - Breastfeeding (vitamin D, iron supplement)
 - Iron-fortified formula
 - Solid foods (types and amounts, begin cup)
 - Elimination

- Infant development
 - Social development
 - Communication skills
 - Sleep
- Safety
 - Car safety seat
 - Poisons
 - Burns (hot water)

- Falls
- Infant walkers
- Drowning
- Choking (finger foods)
- Kitchen safety

- Oral health
 - Brush teeth
 - Avoid bottle in bed

<u>Bright Futures Pre-visit Questionnaire – 6 Month Visit</u> Bright Futures Parent Supplemental Questionnaire – 6 Month Visit

Providers may also wish to use the <u>Visit Documentation Form – 6 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 6 Month Visit</u>.

Nine Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family adaptations (discipline [parenting expectations, consistency, behavior management], cultural beliefs about child-rearing, family functioning, domestic violence)
- Infant independence (changing sleep pattern [sleep schedule], developmental mobility [safe exploration, play], cognitive development [object permanence, separation anxiety, behavior and learning, temperament versus self-regulation, visual exploration, cause and effect], communication)
- Feeding routine (self-feeding, mealtime routines, transition to solids [table food introduction], cup drinking [plans for weaning])
- Safety (car safety seats, burns [hot stoves, heaters], window guards, drowning, poisoning [safety locks], guns)

Anticipatory Guidance

- Family adaptations
 - Limit word "no"
 - Age-appropriate discipline
 - Domestic violence
 - Time for self/partner
- Feeding routine
 - Self-feeding
 - Solid foods
 - Safe foods
 - Using a cup
 - Breastfeeding (vitamin D, iron supplement)
 - Iron-fortified formula

- No bottle in bed
- Brush teeth
- Infant independence
 - Consistent routines
 - Separation anxiety
 - Learning and developing
 - No TV
- Safety
 - Car safety seat
 - Poisons
 - Water/Drowning
 - Falls/Window guards

- Burns
- Guns

<u>Bright Futures Pre-visit Questionnaire – 9 Month Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 9 Month Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 9 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 9 Month Visit</u>.

Twelve Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family support (adjustment to the child's developmental changes and behavior, family-work balance, parental agreement/disagreement about child issues)
- Establishing routines (family time, bedtime, teeth brushing, nap times)
- Feeding and appetite changes (self-feeding, nutritious foods, choices, "grazing")
- Establishing a dental home (first dental checkup, dental hygiene)
- Safety (home safety, car safety seats, drowning, guns)

Anticipatory Guidance

The following topics should be discussed:

- Family support
 - Time for self/partner
 - Community activities
 - Age-appropriate discipline
- Establishing routines
 - Family traditions
 - Nap and bedtime
- Feeding and appetite changes
 - Self-feeding
 - Consistent meals/snacks
 - Variety of nutritious foods
 - Iron-fortified formula

- Establishing a dental home
 - First dentist visit
 - Brush teeth twice a day
 - Limit bottle use (water only)
 - No bottle in bed
- Safety
 - Car safety seat
 - Poisons
 - Water
 - No supervision by young children
 - Sharp objects
 - Guns
 - Home safety
 - Falls

Providers should **consider using tools to elicit parent concerns**, such as:

<u>Bright Futures Pre-visit Questionnaire – 12 Month Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 12 Month Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 12 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent**

education materials that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the *Bright Futures Parent Handout – 12 Month Visit (pdf)*.

Fifteen Month Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Communication and social development (individuation, separation, attention to how child communicates wants and interests, signs of shared attention)
- Sleep routines and issues (regular bedtime routine, night waking, no bottle in bed)
- Temper tantrums and discipline (conflict predictors, distraction, praise for accomplishments, consistency)
- Healthy teeth (brushing teeth, bottle usage)
- Safety (car safety seats, parental use of safety belts, poison, fire safety)

Anticipatory Guidance

The following topics should be discussed:

- Communication and social development
 - Give limited choices
 - Stranger anxiety
 - Read and talk with child
- Sleep routines and issues
 - Consistent routines
 - Night waking
- Temper tantrums and discipline
 - Distraction
 - Praise
 - Consistency

- Healthy teeth
 - First dentist visit
 - Healthy oral habits
 - No bottle
- Safety
 - Car safety seat
 - Home safety
 - Poisons
 - Falls
 - Burns
 - Smoke detectors
 - Carbon monoxide detectors

Providers should consider using tools to elicit parent concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – 15 Month Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 15 Month Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 15 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 15 Month Visit</u>.

Eighteen Month Visit: Priorities for the Visit

- Family support (parental well-being, adjustment to toddler's growing independence and occasional negativity, queries about a new sibling planned or on the way)
- Child development and behavior (adaptation to non-parental care and anticipation of return to clinging, other changes connected with new cognitive gains)
- Language promotion/hearing (encouragement of language, use of simple words and phrases, engagement in reading/singing/talking)
- Toilet training readiness (recognizing signs of readiness, parental expectations)
- Safety (car safety seats; parental use of safety belts; falls, fires, and burns; poisoning; guns)

The following topics should be discussed:

- Family support
 - Family time
 - Time for self and other children
 - Reinforce limits
 - Prepare for new sibling (if necessary)
 - Smoke-free environment
- Child development and behavior
 - Anticipate anxiety
 - Praise
 - Consistent discipline
 - Daily playtime
- Language promotion/hearing

- Read, talk, and sing
- Simple words
- Feelings and emotions
- Toilet training readiness
 - Wait until child is ready
 - Reading books/praise
- Safety
 - Car safety seat
 - Falls
 - Burns
 - Smoke detectors
 - Guns
 - Poisons

Providers should **consider using tools to elicit parent concerns**, such as:

<u>Bright Futures Pre-visit Questionnaire – 18 Month Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 18 Month Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 18 Month Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 18 Month Visit</u>.

Two Year Visit: Priorities for the Visit

- Assessment of language development (how child communicates, expectations for language)
- Temperament and behavior (sensitivity, approachability, adaptability, intensity)
- Toilet training (what have parents tried, techniques, personal hygiene)

- Television viewing (limits on viewing, promotion of reading, promotion of physical activity and safe play)
- Safety (car safety seats, parental use of safety belts, bike helmets, outdoor safety, guns)

The following topics should be discussed:

- Assessment of language development
 - Model appropriate language
 - Daily reading
 - Following 1–2-step commands
 - Listen and respond to child
- Temperament and behavior
 - Praise, respect
 - Help express feelings
 - Self-expression
 - Playing with other children
 - Plan for frequent toilet breaks
- Toilet training

- When child is ready
- Personal hygiene
- Television viewing
 - Limit TV viewing to no more than 1–2 hours/day
 - TV alternatives: reading, games, singing
 - Encourage physical activity
- Safety
 - Car safety seat
 - Bike helmet
 - Supervise outside
 - Guns

Providers should consider using tools to elicit parent concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – 2 Year Visit</u> Bright Futures Parent Supplemental Questionnaire – 2 Year Visit

Providers may also wish to use the <u>Visit Documentation Form – 2 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 2 Year Visit</u>.

Two And A Half Year Visit: Priorities for the Visit

- Family routines (parental consistency, day and evening routines, enjoyable family activities)
- Language promotion and communication (interactive communication through song, play, and reading)
- Promoting social development (play with other children, limited reciprocal play, imitation of others, choices)
- Preschool considerations (readiness for early childhood programs, playgroups, or playdates)
- Safety (water safety, car safety seats, outdoor health and safety [pools, play areas, sun exposure], pets, fires and burns)

The following topics should be discussed:

- Family routines
 - Family meals
 - Family activities
- Language promotion and communication
 - Limit TV
 - Daily reading
 - Listen and repeat to child
- Social development
 - Supervised play with other children
 - Setting limits
 - Emerging independence

- Preschool considerations
 - Group activities/preschool (if possible)
 - Toilet training
- Safety
 - Car safety seat
 - Water
 - Appropriate supervision
 - Sun exposure
 - Fire safety
 - Smoke detectors
 - Outdoor safety
 - Playground
 - Dogs

Providers should consider using tools to elicit parent concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – 2½ Year Visit</u> Bright Futures Parent Supplemental Questionnaire – 2½ Year Visit

Providers may also wish to use the <u>Visit Documentation Form – 2½ Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 2½ Year Visit</u>.

Three Year Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- Family support (family decisions, sibling rivalry, work balance)
- Encouraging literacy activities (singing, talking, describing, observing, reading)
- Playing with peers (interactive games, play opportunities)
- Promoting physical activity (limits on inactivity)
- Safety (car safety seats, pedestrian safety, falls from windows, guns)

Anticipatory Guidance

- Family support
 - Show affection
 - Manage anger
 - Reinforce appropriate behavior
 - Reinforce limits
 - Find time for yourself
- Encouraging literacy activities

- Read, sing, play
- Talk about pictures in books
- Encourage child to talk
- Encourage appropriate play
- Playing with peers
 - Encourage fantasy play

- Encourage play with peers
- Promoting physical activity
 - Family exercise, activities
 - Limit screen time maximum 1–2 hours/day
 - No TV in bedroom
- Safety

- Car safety seat
- Supervise play near streets, cars
- Safety near windows
- Guns

<u>Bright Futures Pre-visit Questionnaire – 3 Year Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 3 Year Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 3 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 3 Year Visit</u>.

Providers may also want to refer the parents to their local public school district's Child Find services, which include screenings related to vision, hearing, physical development, social development, and cognitive development. Results of these screenings may indicate need for Early Childhood Special Education, a free service provided by federal and state funds. Eligibility for these programs begins at age 3.

Four Year Visit: Priorities for the Visit

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in this visit:

- School readiness (structured learning experiences, opportunities to socialize with other children, fears, friends, fluency)
- Developing healthy personal habits (daily routines that promote health)
- Television/media (limits on viewing, promotion of physical activity and safe play)
- Child and family involvement and safety in the community (activities outside the home, community projects, educational programs, relating to peers and adults, domestic violence)
- Safety (belt positioning booster seats, supervision, outdoor safety, guns)

Anticipatory Guidance

- School readiness
 - Model behavior
 - Be sensitive to child's feelings
 - Encourage play with other children
 - Consider preschool
 - Daily reading
 - Talk with child

- Healthy personal habits
 - Calm bedtime routine
 - Brush teeth twice daily
 - Daily physical activity
- TV/media
 - Limit TV/video to 1–2 hours/day
 - No TV in bedroom
- Child and family involvement

- Community activities
- Expect curiosity about body— answer questions using proper terms
- Safety rules with adults
- Good and bad touches
- How to seek help when needed

- Safety
 - Appropriately restrained in all vehicles
 - Supervise all outdoor play
 - Guns

<u>Bright Futures Pre-visit Questionnaire – 4 Year Visit</u> <u>Bright Futures Parent Supplemental Questionnaire – 4 Year Visit</u>

Providers may also wish to use the <u>Visit Documentation Form – 4 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 4 Year Visit</u>.

Providers may also wish to refer parents to their local public school district's Child Find services, which include screenings related to vision, hearing, physical development, social development, and cognitive development. Results of these screenings may indicate need for Early Childhood Special Education, a free service provided by federal and state funds. Eligibility for these programs begins at age three.

Five and Six Year Visits: Priorities for the Visits

The first priority is to attend to the concerns of the parents. In addition, the following topics should be considered priorities for discussion in these visits:

- School readiness (established routines, after-school care and activities, parentteacher communication, friends, bullying, maturity, management of disappointments, fears)
- Assure that all health requirements for school attendance are met (physical exam form available at the IDPH and ISBE websites; kindergarten entry eye examinations [not screening but exam]; immunizations and/or indicated medical waivers completed by health care provider)
- Mental health (family time, routines, temper problems, social interactions)
- Nutrition and physical activity (healthy weight; appropriate well-balanced diet; increased fruit, vegetable, whole-grain consumption; adequate calcium intake; 60 minutes of exercise a day)
- Oral health (regular visits with dentist, daily brushing and flossing, adequate fluoride)
- Safety (pedestrian safety, booster seat, safety helmets, swimming safety, child sexual abuse prevention, fire escape/drill plan and smoke detectors, carbon monoxide detectors/alarms, guns)

Anticipatory Guidance

- School readiness
 - Establish routines
 - After-school care/activities
 - Friends
 - Bullying
 - Communicate with teachers
- Oral health
 - Regular dentist visits
 - Brushing/Flossing
 - Fluoride
- Nutrition and physical activity
 - Healthy weight
 - Well-balanced diet, including breakfast
 - Fruits, vegetables, whole grains
 - Adequate calcium
 - 60 minutes of exercise/day

- Mental health
 - Family time
 - Anger management
 - Discipline for teaching not punishment
 - Limit TV
- Safety
 - Sexual safety
 - Pedestrian safety
 - Safety helmets
 - Swimming safety
 - Fire escape plan
 - Smoke/carbon monoxide detectors
 - Guns
 - Sun
 - Appropriately restrained in all vehicles

<u>Bright Futures Pre-visit Questionnaire – 5 Year Visit</u>

Bright Futures Pre-visit Questionnaire - 6 Year Visit

Bright Futures Parent Supplemental Questionnaire – 5 and 6 Year Visits

Providers may also wish to use the <u>Visit Documentation Form – 5 and 6 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Parent Handout – 5 and 6 Year Visits</u>.

Seven and Eight Year Visits: Priorities for the Visits

- School (adaptation to school, school problems [behavior or learning issues], school performance/progress, involvement in school activities and after-school programs, bullying, parental involvement, IEP or special education services)
- Development and mental health (independence, self-esteem, establishing rules and consequences, temper problems, managing and resolving conflicts, puberty/pubertal development)
- Nutrition and physical activity (healthy weight, appropriate food intake, adequate calcium, water instead of soda, adequate physical activity in organized sports/after-school programs/fun activities, limits on screen time)
- Oral health (regular visits with dentist, daily brushing and flossing, adequate fluoride)

 Safety (knowing child's friends and their families, supervision with friends, safety belts/booster seats, helmets, playground safety, sports safety, swimming safety, sunscreen, smoke-free home/vehicles, guns, careful monitoring of computer use [games, Internet, e-mail])

Anticipatory Guidance

The following topics should be discussed:

- School
 - Show interest in school
 - Communicate with teachers
- Development and mental health
 - Encourage independence
 - Praise strengths
 - Be a positive role model
 - Discuss expected body changes
- Nutrition and physical activity
 - Encourage proper nutrition
 - Eat meals as a family
 - 60 minutes of physical activity daily
 - Limit TV and screen time

- Oral health
 - Dental visits twice a year
 - Brush teeth twice a day
 - Floss teeth daily
 - Wear mouth guard during sports
- Safety
 - Know child's friends
 - Home emergency plan
 - Safety rules with adults
 - Appropriate vehicle restraint
 - Helmets and pads
 - Supervise around water
 - Smoke-free environment
 - Guns
 - Monitor computer use

Providers should consider using tools to elicit parent concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – 7 Year Visit</u> <u>Bright Futures Pre-visit Questionnaire – 8 Year Visit</u>

Bright Futures Parent Supplemental Questionnaire – 7 and 8 Year Visits

Providers may also wish to use the <u>Visit Documentation Form – 7 and 8 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Patient Handout – 7 and 8 Year Visits</u> and <u>Bright Futures Parent Handout – 7 and 8 Year Visits</u>.

Nine and 10 Year Visits: Priorities for the Visits

- School (school performance, homework, bullying)
- Development and mental health (emotional security and self-esteem, family communication and family time, temper problems and setting reasonable limits, friends, school performance, readiness for middle school, sexuality [pubertal onset, personal hygiene, initiation of growth spurt, menstruation and ejaculation, loss of "baby fat" and accretion of muscle, sexual safety])

- Nutrition and physical activity (weight concerns, body image, importance of breakfast, limits on high-fat foods, water rather than soda or juice, eating as a family, physical activity)
- Oral health (regular visits with dentist, daily brushing and flossing, adequate fluoride)
- Safety (safety belts, helmets, bicycle safety, swimming, sunscreen, tobacco/alcohol/drugs, knowing child's friends and their families, supervision of child with friends, guns)

The following topics should be discussed:

- Development and mental health
 - Encouraging independence and selfresponsibility
 - Be a positive role model discuss respect, anger
 - Know child's friends and importance of peers
 - Expect preadolescent behaviors
 - Answer questions and discuss puberty
 - Safety rules with adults
- Safety
 - Booster seat
 - Teach to swim/water safety
 - Sunscreen
 - Avoid tobacco, alcohol, drugs
 - Guns

- School
 - Show interest in school
 - Quiet space for homework
 - Address bullying
- Nutrition and physical activity
 - Encourage proper nutrition
 - 60 minutes of physical activity daily
 - Limit TV and screen time
- Oral health
 - Dental visits twice a year
 - Brush teeth twice a day
 - Floss teeth daily
 - Wear mouth guard during sports

Providers should consider using tools to elicit parent concerns, such as:

Bright Futures Pre-visit Questionnaire – 9 Year Visit

Bright Futures Pre-visit Questionnaire - 10 Year Visit

Bright Futures Parent Supplemental Questionnaire – 9 and 10 Year Visits

Providers may also wish to use the <u>Visit Documentation Form – 9 and 10 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Patient Handout – 9 and 10 Year Visits</u> and <u>Bright Futures Parent Handout – 9 and 10 Year Visits</u>.

Early Adolescent Visits (11 To 14 Years): Priorities for the Visits

The first priority is to attend to the concerns of the adolescent and his/her parents. In addition, the following topics should be considered priorities for discussion in these visits. Including all the priority issues in every visit may not be feasible, but the goal should be to address these issues over the course of the four early adolescence visits:

- Physical growth and development (physical and oral health, body image, healthy eating, physical activity)
- Social and academic competence (connectedness with family, peers, and community; interpersonal relationships; school performance)
- Emotional well-being (coping, mood regulation and mental health, sexuality)
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs)
- Violence and injury prevention (safety belt and helmet use, substance abuse and riding in a vehicle, guns, interpersonal violence [fights], bullying)
- Required middle school health requirements for school attendance (e.g., physical exam prior to entry into 6th grade, adolescent immunizations)

Anticipatory Guidance

The following topics should be discussed:

- Physical growth and development
 - Brush/Floss teeth
 - Regular dentist visits
 - Body image
 - Balanced diet
 - Limit TV
 - Physical activity
- Social and academic competence
 - Help with homework when needed
 - Encourage reading/school
 - Community involvement
 - Family time
 - Age-appropriate limits
 - Friends
- Risk reduction
 - Tobacco, alcohol, drugs
 - Prescription drugs
 - Know friends and activities
 - Sex

- Emotional well-being
 - Decision-making
 - Dealing with stress
 - Mental health concerns
 - Sexuality/Puberty
- Violence and injury prevention
 - Seat belts, no ATV
 - Guns
 - Safe dating
 - Conflict resolution
 - Bullying
 - Sport helmets
 - Protective gear

Providers should consider using tools to elicit patient/parent concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – Older Child/Younger Adolescent Visits</u> <u>Bright Futures Pre-visit Questionnaire – Older Child/Early Adolescent Visits—For</u> <u>Parents</u>

<u>Bright Futures Pre-visit Questionnaire - Early Adolescent Visits</u> <u>Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger</u> Adolescent Visits <u>Bright Futures Parent Supplemental Questionnaire - Older Child/Early Adolescent Visits</u> Bright Futures Adolescent Supplemental Questionnaire - Early Adolescent Visits

Providers may also wish to use the <u>Visit Documentation Form – 11 to 14 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Patient Handout – Early Adolescent Visits</u> and <u>Bright Futures Parent Handout – Early Adolescent Visits</u>.

Middle Adolescent Visits (15 To 17 Years): Priorities for the Visit

The first priority is to attend to the concerns of the adolescent and his/her parents. In addition, the following topics should be considered priorities for discussion in these visits. Including all the priority issues in every visit may not be feasible, but the goal should be to address these issues over the course of the three middle adolescence visits:

- Physical growth and development (physical and oral health, body image, healthy eating, physical activity)
- Social and academic competence (connectedness with family, peers, and community; interpersonal relationships; school performance)
- Emotional well-being (coping, mood regulation and mental health, sexuality)
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs)
- Violence and injury prevention (safety belt and helmet use, driving/graduated license and substance abuse, guns, interpersonal violence/dating violence)

Anticipatory Guidance

The following topics should be discussed:

- Physical growth and development
 - Balanced diet
 - Physical activity
 - Limit TV
 - Protect hearing
 - Brush/Floss teeth
 - Regular dentist visits
- Social and academic competence
 - Age-appropriate limits
 - Friends/relationships
 - Community involvement
 - Encourage reading/school
 - Rules/Expectations
 - Planning for after high school

- Emotional well-being
 - Dealing with stress
 - Decision-making
 - Mood changes
 - Sexuality/Puberty
- Risk reduction
 - Tobacco, alcohol, drugs
 - Prescription drugs
 - Sex
- Violence and injury prevention
 - Seat belts
 - Guns
 - Conflict resolution
 - Driving restriction
 - Sports/recreation safety

Providers should consider using tools to elicit patient concerns, such as:

Bright Futures Adolescent Supplemental Questionnaire 15 to 17 Year Visits

Bright Futures Adolescent Supplemental Questionnaire – 15 to 17 Year Visits

Providers may also wish to use the <u>Visit Documentation Form – 15 to 21 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance provided during the visit and/or highlight important areas that are not able to be addressed, such as the <u>Bright Futures Patient Handout – 15 to 17 Year Visits</u> and <u>Bright Futures Parent Handout – 15 to 17 Year Visits</u>.

Late Adolescent Visits (18 To 21 Years): Priorities for the Visit

The first priority is to attend to the concerns of the adolescent and his/her parents. In addition, the following topics should be considered priorities for discussion in these visits. Including all the priority issues in every visit may not be feasible, but the goal should be to address these issues over the span of the four late adolescence visits:

- Physical growth and development (physical and oral health, body image, healthy eating, physical activity)
- Social and academic competence (connectedness with family, peers, and community; interpersonal relationships; school/job performance)
- Emotional well-being (coping, mood regulation and mental health, sexuality)
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs)
- Violence and injury prevention (safety belts and helmets, driving and substance abuse, access to guns, interpersonal violence [dating violence, stalking])

Anticipatory Guidance

The following topics should be discussed:

- Physical growth and development
 - Balanced diet
 - Physical activity
 - Limit TV
 - Protect hearing
 - Brush/Floss teeth
 - Regular dentist visits
- Social and academic competence
 - Age-appropriate limits
 - Friends/relationships
 - Community involvement
 - Encourage reading/school
 - Rules/Expectations
 - Planning for after high school

- Emotional well-being
 - Dealing with stress
 - Decision-making
 - Mood changes
 - Sexuality/Puberty
- Risk reduction
 - Tobacco, alcohol, drugs
 - Prescription drugs
 - Sex
- Violence and injury prevention
 - Seat belts
 - Guns
 - Conflict resolution
 - Driving restriction
 - Sports/recreation safety

Providers should consider using tools to elicit patient concerns, such as:

<u>Bright Futures Pre-visit Questionnaire – 18 to 21 Year Visits</u> <u>Bright Futures Adolescent Supplemental Questionnaire – 18 to 21 Year Visits</u>

Providers may also wish to use the <u>Visit Documentation Form – 15 to 21 Year Visit</u> to record elements of the health supervision visit. Providers should also use **patient/parent education materials** that can be used to complement guidance

provided during the visit and/or highlight important areas that are not able to be addressed, such as the *Bright Futures Patient Handout – 18 to 21 Year Visits*.

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HK- 2 Trauma Informed Medical Home Information and Resources

The <u>National Institute of Mental Health</u> defines childhood trauma as emotionally painful or distressful childhood experience (s) which result in mental and physical sequelae. An easy way to remember this is to think of the three "E's" – the *Event*, the child's *Experience* of the event and the *Effect* of the event on the child's life.

A goal of pediatric providers should be to ensure that children and families who experience trauma have access to quality treatment and support. One way to accomplish this goal is to make sure that the practice providing care is trauma-informed. Trauma-informed organizations and programs are those that create and use practices based on an understanding of the vulnerabilities of trauma survivors that traditional service delivery approaches may not appreciate. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center for Trauma-Informed Care, trauma-informed organizations provide services that are supportive while avoiding re-traumatization. A trauma-informed program has assessed its organization, management, and service delivery system and modified policies, procedures, and practice to include a basic understanding of how trauma affects the life of an individual seeking or using services. A trauma-informed medical home has addressed these same elements to ensure appropriate response to victimized children and families in a safe and secure space.

Medical Implications of Trauma for Children and Their Families

According to the <u>Illinois Childhood Trauma Coalition (ICTC) (pdf)</u>, childhood trauma may disrupt a child's normal development and potentially lead to physical, emotional, cognitive, behavioral and social problems. Research can teach us a lot about the implications of childhood trauma. For example, the <u>Adverse Childhood Experiences</u> (ACE) Study (pdf) examined the childhood origins of many of our nation's leading health and social problems. The key concept underlying the study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, prolonged absence of a significant person (e.g. military service or incarceration), living in a home where there are substance abuse issues, mental illness, parental discord, or crime correlate with an increased adult risk of unhealthy behaviors, violence, re-victimization, disease, disability and premature mortality. For example, the ACE Study found that a person with an ACE score of four (indicating 4 Adverse Childhood Experiences) is 390% more likely to have chronic obstructive pulmonary disease and 460% more likely to be depressed than someone with a score of 0.

Left untreated, ACE can lead to a lifetime of distress and the potential for early death. In a study of a Chicago juvenile detention center, 84% of the youth reported multiple exposures to trauma, with the majority experiencing six or more events. A general population study of children and adolescents aged 9-16 years of age suggests 25% had experienced at least one potentially traumatic event. Studies like these and the ACE study present compelling evidence that we need to be diligent in prevention and early intervention efforts in response to childhood trauma.

Medical Response Best Practice

The <u>National Child Traumatic Stress Network</u> defines a service system with a traumainformed perspective as one in which programs, agencies, and providers:

- Routinely screen for trauma exposure and related symptoms
- Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
- Make resources available to children, families, and providers on trauma exposure, its impact, and treatment
- Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
- Address parent and caregiver trauma and its impact on the family system
- Emphasize continuity of care and collaboration across child-service systems
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience

There are many actions medical homes can take to make their practices traumainformed. Medical homes and their staff can:

- Ensure that general trauma informed questions are built into family conversations in the practice
- Identify programs and providers in the community that are able to provide evidence based support and therapy. For example, therapists treating trauma exposed children should have received trauma focused training.
- Collaborate with non-traditional programs that offer more flexibility in their treatment and healing process for the families.
- Incorporate concepts that include recognition of cycles of intergenerational trauma, and stopping this cycle of trauma by building strengths and resilience in children into the pediatric practice or program
- Encourage the review of positive ways of coping and available resources/supports as part of building relationships with families and children

Summary

Many children and families seen by pediatric providers have been through difficult situations and events. Through embracing trauma-informed best practices, whether it be in a brief interaction or an intensive clinical intervention, medical homes are in a unique position to work with traumatized children and families to help them begin to heal and create strength and resilience.

Resources and References

Adverse Childhood Experiences (ACE) Study

Website:

The Health and Social Impact Study (pdf)

Child Trauma Academy website

Child Sex Abuse Prevention and Protection Center – includes resources for use in practice, such as "Warning Signs of Sexual Abuse" and "Nine Questions to Ask When Selecting a Program for Your Child"

Website: http://www.stopitnow.org

Domestic Violence – Prevention and Intervention

Website: <u>Domestic Violence – Prevention and Intervention webpage</u>

■ Phone: 1-877-TO END DV (1-877-863-6338)

■ TTY: 1-877-863-6339

ICAAP - Illinois PROTECT (Promoting Resiliency of Trauma-Exposed Communities Together)

Website:

ICAAP - Illinois PROTECT website

Griffin, G. & Studzinski, A. (2010). A White Paper for ICTC: Child Trauma as a Lens for the Public Health Sector to Consider When Viewing Its Youth:

Child Trauma as a Lens for the Public Health Sector (pdf)

The International Society for Traumatic Stress Studies

The International Society for Traumatic Stress Studies website

The National Child Traumatic Stress Network
The National Child Traumatic Stress Network website

Reach Out and Read Program

Early exposure to language is critical for both healthy child development and school readiness. Research shows that when pediatricians and other health care professionals promote early literacy according to the Reach Out and Read model, there is a significant effect on parental behavior, beliefs, and attitudes towards reading aloud, as well as improvements in the language scores of at-risk young children who participate. These effects have been found in ethnically diverse low-income families, in all areas of the country, regardless of parental literacy.

The Reach Out and Read model has a three-pronged approach in promoting child development and preparing young children to succeed in school:

- In the exam room, trained providers provide anticipatory guidance to parents about the importance of reading aloud;
- At each checkup from 6 months to 5 years, the child receives a new, developmentally appropriate book to take home;
- Clinic waiting rooms are transformed into literacy rich areas with volunteer readers modeling techniques of reading aloud.

The Reach Out and Read model is an evidence-based strategy with 14 peer-reviewed and published studies available for review on the Reach Out and Read: The Evidence website (pdf). The body of published research supporting the efficacy of the Reach Out and Read model is more extensive than for any other psychosocial intervention in general pediatrics.

Reach Out and Read is recommended in the Bright Futures Guidelines as a strategy for use during well child visits from ages 6 months to 5 years, and is endorsed by the American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners.

For more information about the Reach Out and Read program in Illinois, please visit the website, http://www.reachoutandreadillinois.org/.

Care Coordination Information and Resources

Care coordination is not consistently or uniformly defined by the various organizations and researchers that have addressed the topic. However, the National Coalition on Care Coordination (N3C) definition is commonly used. It describes care coordination as, "a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care."

Care coordination helps ensure a patient's needs and preferences for care are understood, and that those needs and preferences are shared between providers, patients, and families as a patient moves from one healthcare setting to another and/or from one support system to another. Care among many different providers must be well-coordinated to avoid waste, over-, under-, or misuse of prescribed medications, and conflicting plans of care.

A portfolio of care coordination preferred practices and performance measures includes structure, process, and outcome measures to evaluate physician office capacity for access, continuity, communication, and tracking of patients across providers and settings. However, there are some best practices that most medical homes can incorporate to enhance care coordination. Examples include:

- Develop strategies for communication among referring organizations by using standardized referral forms
- Identify resources to help families access referral systems.
- Know more about what services are provided through Prevention Programs,
 Early Intervention and Special Education
- As the medical home, plan with your staff how to manage care coordination after referring families to Prevention Programs, Early Intervention or Special Education

More information about Illinois-specific care coordination resources can be accessed using the following:

- HFS' Care Coordination webpage
 - In response to Medicaid Reform and the new era in care management, Illinois is expanding its managed care programs to include managed care entities.
 Care coordination will be provided to most Medicaid clients by these new managed care entities.
- Statewide Provider Database (SPD) Informational Brochure
 - The SPD is an online resource for service and program information throughout Illinois. This online database includes comprehensive information on services throughout Illinois covering mental health, substance abuse, parenting, domestic violence, early childhood, health clinics, non-clinical services (e.g., after-school, recreational programs, tutoring, mentoring, vocational programs), and homelessness resources.

- Contact Eileen Reilly (Email: Eileen.Reilly@illinois.gov) to get access to the SPD
- Statewide Provider Database Login website
 - Contact Eileen Reilly (Email: Eileen.Reilly@illinois.gov) to get access to the SPD
 - Illinoisoutcomes.dcfs.illinois.gov
- School Health and Nursing Services
 - The Illinois State Board of Education (ISBE) employs a Registered Nurse to provide consultation on school health services and other health issues. The ISBE school directory includes contact information for each of the state's public schools. It also maintains a database of school employees, including nurses. For contact information for the school health services coordinator at any public school district, contact ISBE at 312-814-5560 and ask for the school nurse consultant.
- Standardized Illinois Early Intervention Referral Form (pdf)
 - For making referrals to DHS's Early Intervention program; consent is HIPAA and FERPA compliant so that providers making the referral receive information about the outcome of the referral.
- Illinois Early Intervention Program Referral Fax Back Form (pdf)
 - Providers who initiated a referral to EI using the Standardized Illinois Early Intervention Referral Form will receive the referral fax back form from the local Early Intervention Child and Family Connections office. This form is not completed by the referring provider, it is a report back from EI regarding the outcome of the referral made by the provider.

Text4baby

HFS and EverThrive (formerly the Illinois Maternal and Child Health Coalition), encourage the use of <u>Text4baby</u>, a free mobile texting service designed to promote maternal and child health.

EverThrive serves as the Illinois state affiliate of the Text4baby outreach campaign. Text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition and provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Women who sign up for the service by texting BABY to 511411(or BEBE for Spanish) will receive free text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health: immunization, nutrition, seasonal flu, mental health, birth defects prevention, oral health and safe sleep. Text4baby messages also connect women to prenatal and infant care services. Please join our efforts in promoting the Text4baby program to all pregnant women and new mothers in Illinois by encouraging women to sign up. Following are ideas for promoting Text4baby:

- Send an email to your staff announcing your support of Text4baby and providing them with resources.
- Print copies of the flyers, available on the Text4baby Web site and place them around your facility.
- Display posters in waiting areas and exam rooms.
- Add a Text4baby web banner or button to your website's homepage
- Add a web page within your site about Text4baby and how your agency is helping promote the service
- Add a link to Text4baby on your agency's Facebook page
- Include information about Text4baby in reminders to patients and other mailings.
- Host a "baby shower" in your office/clinic for pregnant patients and their families and distribute promotional items and information about Text4baby.
- Use the following script when talking to women: If you're pregnant or a new mom, there is a new free service called Text4baby that can help keep you and your baby healthy. Text4baby will send 3 text messages each week to your cell phone with expert health tips to help you through your pregnancy and your baby's first year. It's free to sign up and the messages are free. To sign up, text BABY to 511411. To sign up for Text4baby in Spanish, text BEBE to 511411. You can also sign up and find out more at the Text4baby Web site. Text4baby is an educational service of the National Healthy Mothers, Healthy Babies Coalition.

EverThrive has posters, tear-offs and other materials for distribution. To order free Text4baby materials please contact:

Website: <u>EverThrive website</u>Phone: 1-312-491-8161

Breastfeeding Information and Resources

This appendix provides information and best practices around breastfeeding as recommended in the *Illinois Physicians' Statement on Breastfeeding* for the State of Illinois, developed by the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Illinois Academy of Family Physicians, and the Illinois Section of the American Congress of Obstetricians and Gynecologists. To learn more, download the complete policy statement and list of references from the *Illinois Physicians' Statement on Breastfeeding* website or view a presentation on the ICAAP Illinois Physicians Statement on Breastfeeding Webinar website about these recommendations.

Breastfeeding provides recognized health benefits for both mother and child. Infants that are formula fed are at risk for increased incidence of numerous infectious childhood diseases, Sudden Infant Death Syndrome (SIDS), type 1 and 2 diabetes, and childhood obesity. For women, breastfeeding reduces the incidence of postpartum bleeding, breast and ovarian cancer, metabolic syndrome, hypertension, diabetes and heart disease.

According to the most recent Centers for Disease Control and Prevention Maternity Practices in Infant Nutrition and Care (mPINC) survey, Illinois ranks 31st among all states in terms of maternity practices related to infant feeding and care. Additional action is needed within the state of Illinois to advance breastfeeding as the normal feeding practice for infants and young children and to meet the Healthy People 2020 goals for increasing the proportion of infants who are breastfed.

The Continuum and Coordination of Care

A woman who wants to breastfeed will require support at every step of the breastfeeding continuum from preconception through the weaning process. A coordinated system of care between the various settings – from the physician's office to the hospital and into the community – will increase the likelihood that mothers receive the necessary support at each time and place. Collaboration among family physicians, obstetricians, pediatricians, nurse-midwives, lactation consultants, and other health professionals, as well as doulas and peer counselors, is a key aspect of this continuum.

Preconception Care

Breastfeeding should be promoted as normative and conversations about overall breast health ought to include breastfeeding. A well-woman or routine health maintenance visit is an opportunity to discuss breastfeeding and any potential problems that may factor into the ability to breastfeed in the future.

Prenatal Care

Obstetricians and family physicians are in a unique position to "counsel mothers about the health impact of breastfeeding and to ensure that mothers and infants receive appropriate, evidence-based care." ¹

- Discuss the infant feeding decision at the first prenatal visit and continue to discuss at every visit throughout the prenatal period.
- Address concerns or misunderstandings regarding breastfeeding. Only a small percentage of women are physiologically unable to breastfeed.
- Provide appropriate education or referrals for education to aid in maternal decision-making. Include the mother's support persons in the education and decision process.
- Elicit any factors in the family medical history that make breastfeeding more important.
 - Strongly encourage breastfeeding for women with a family or personal history of obesity, diabetes, atopic disease, and certain cancers as it has been shown to decrease the incidence of these conditions.
- Identify any medical contraindications to breastfeeding as well as risk factors for breastfeeding problems, including:
 - A history of prior breast procedures or surgeries, which may indicate the need for a prenatal referral for lactation support.
 - A history of infertility, polycystic ovary disease, hypothyroidism, and anatomical issues impacting lactation.
- Perform a complete breast assessment to evaluate the mother's anatomy and anticipate any difficulties with breastfeeding.
- Encourage the woman and her support persons to attend breastfeeding classes and/or peer support groups.
- Provide women with connections to lactation resources in the community prior to delivery.
 - Referrals for prenatal lactation consultations are especially recommended for women with high-risk pregnancies or anticipated problems with breastfeeding.

In-Hospital Care

In-hospital care should focus on providing support to initiate and refine the techniques of breastfeeding.

- Advocate for evidence-based maternal and infant care practices such as the UNICEF/WHO Baby-Friendly Hospital Initiative:
 - Have a written breastfeeding policy and routinely communicate it to all health care staff
 - Train all health care staff in skills necessary to implement this policy.
 - Inform all pregnant women about the benefits and management of breastfeeding.
 - Help mothers initiate breastfeeding within one hour of birth.

¹ Stuebe A, Schwarz EB. The Risks and Benefits of Infant Feeding Practices for Women and Their Children. *J Perinatol.* 2010;30(3):155-162.

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- Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
- Give newborn infants no food or drink other than breast milk, unless medically indicated.
- Practice "rooming in" allow mothers and infants to remain together 24 hours a day.
- Encourage breastfeeding on demand.
- Give no pacifiers or artificial nipples to breastfeeding infants.
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
- Encourage the use of doulas during labor and birth to decrease the rate of interventions which may impact breastfeeding (early epidurals, medications, Csections).
- Advocate for adequate staffing for in-hospital lactation support during all shifts. Encourage hospital administrators to include breastfeeding in acuity criteria for staffing. It is recommended that breastfeeding specialists, including lactation consultants and breastfeeding counselors and/or peer counselors, be available to provide lactation support in proportion to the number of deliveries at the hospital as outlined by the Association of Women's Health, Obstetric and Neonatal Nurses and the International Lactation Consultant Associations (AWHONN).
- Implement a peer counselor program if one does not already exist.
- Ensure that all women receive information regarding lactation resources in the community.
- Guarantee sufficient breast pumps are available in the hospital for all lactating women (patients and employees).
- Limit the influence of formula companies in the hospital by minimizing the use of formula and eliminating free gifts to staff and breastfeeding mothers. Encourage hospitals to store formula away from parents' view and out of the cribs or bassinettes of babies that are breastfeeding.
- Recognize the special breastfeeding concerns for high-risk pregnancies and births and address them appropriately.
 - For all premature and other high-risk infants, recommend breast milk (direct or expressed).
 - If the baby is not breastfeeding, educate mothers about initiating hand expression within two hours, and pumping within six hours after birth.
 - When indicated, breastmilk-based fortifiers should be utilized.
 - For infants whose mothers are unable to provide their own milk, banked breast milk may be provided.
- Facilitate communication between hospitals and outpatient providers to ensure continuity of breastfeeding-related care for patients.

Post-Discharge Care

Post-discharge care is critical to the maintenance of breastfeeding. Many mothers initiate breastfeeding but do not continue for the recommended duration of exclusive breastfeeding for six months and continued breastfeeding for two years. Education and support during the first two weeks can increase duration and exclusivity, preventing premature discontinuation of breastfeeding.

- Ensure that mother and infant are evaluated soon after discharge. At a minimum, arrange follow-up with a qualified health care professional when the infant is three to five days old and again at two to three weeks of age.
 - Address breastfeeding issues that arise during these early assessment times directly by the provider or refer promptly for outside lactation support services.
- Refer mothers to peer support groups as identified prenatally.
- Obtain and share lists of referral resources with lactating mothers.
- Ensure that mothers who qualify have access to free or reduced-cost breast pumps.
- Provide continuing support for breast milk pumping and storage as the mother returns to work.

Education and Support in the Clinic/Office Setting

- Create an environment which promotes breastfeeding as normative.
- Establish a breastfeeding friendly clinic:
 - Provide educational materials and videos in waiting and examination rooms.
 - Offer seating for women with infants that keeps breastfeeding in mind.
 - Offer a call-in telephone number where mothers can receive lactation advice.
 - Have breast pumps available and a designated pumping room or space that is not a bathroom for patients and employees to use.
- Avoid conflicts of interest by declining free formula samples and removing products with formula company branding.
- Promote physician education through self-directed learning and CME courses related to breastfeeding.
- Identify resources that can improve reimbursement for lactation support.
- Learn about local community support and resources for lactating mothers, such as resource lists (frequently offered by hospitals and local breastfeeding coalitions) and websites such as the International Lactation Consultant Association (see Breastfeeding Resources).
- Be supportive of all family members and others that are assisting the breastfeeding mother.

Breastfeeding Resources

Chicago Area Breastfeeding Coalition

Chicago Area Breastfeeding Coalition website

Chicago Region Breastfeeding Task Force

Chicago Region Breastfeeding Task Force website

International Lactation Consultant Association

International Lactation Consultant Association website

La Leche League of Illinois

La Leche League of Illinois website

Illinois WIC - General Information

Illinois WIC - General Information webpage

Illinois WIC - Breastfeeding Peer Counselor Program

Illinois WIC - Breastfeeding Peer Counselor Program webpage

Illinois State Breastfeeding Taskforce - breastfeeding laws

Illinois State Breastfeeding Taskforce - breastfeeding laws website

Northern Illinois Lactation Consultants Association – NILCA

Northern Illinois Lactation Consultant Association – NILCA website

United States Breastfeeding Committee - workplace support in Federal law <u>United States Breastfeeding Committee website</u>

Women, Infants, and Children (WIC) Program and Resources

WIC is a public health nutrition program under the USDA providing nutrition education, nutritious foods, breastfeeding support, and healthcare referrals for income-eligible women who are pregnant or postpartum, infants, and children up to age five.

To find a local WIC office:

DHS office locator: Office Locator
State WIC office: 1-217-782-2166

DHS hotline: 1-800-843-6154 or 1-800-447-6404 (TTY)

For more information about the WIC program:

General WIC information: General WIC webpage

WIC "Make a Difference" brochure

• (English): <u>WIC "Make a Difference" webpage</u>

Website (Spanish): http://www.dhs.state.il.us/page.aspx?item=70917

PDF (English):

Make a Difference Brochure (pdf)

■ PDF (Spanish):

Make a Difference Spanish (pdf)

Smoking and Tobacco Use Cessation Coding Information and Resources

Counseling Procedure Codes

Effective with dates of service on and after January 1, 2014, tobacco cessation counseling services for those through age 20, pregnant and up to 60-day post-partum women age 21 and over may be a separately billable service under the following procedure codes:

99406 – Smoking and Tobacco Use Cessation Counseling Visit; Intermediate, Greater than 3 Minutes Up to 10 Minutes
99407 – Smoking and Tobacco Use Cessation Counseling Visit; Intensive, Greater than 10 Minutes

HFS will reimburse up to a maximum of three quit attempts per calendar year, with up to four individual face-to-face counseling sessions per quit attempt. The 12 maximum counseling sessions include any combination of the two procedure codes listed above. These counseling sessions must be provided by, or under the supervision of, a physician, or by any other health care professional who is legally authorized to furnish such services under State law, and who is authorized to provide Medicaid covered services other than tobacco cessation services.

In addition, the patient's medical record must be properly documented with provider signature, and include the total time spent and what was discussed during the counseling session, including cessation techniques, resources available and follow-up.

Note: Children through age 20 are not restricted to the maximum twelve counseling sessions.

Illinois Smoking Cessation Resources

Illinois Tobacco Quitline

- Illinois Tobacco Quitline website
- Phone: 1-866-QUIT-YES (1-866-784-8937)

Illinois Tobacco-Free Communities - Illinois Department of Public Health

Website: Illinois Tobacco-Free Communities website

Smoke-free Illinois - Illinois Department of Public Health

Smoke-free Illinois website

Stop Smoking, American Lung Association in Illinois - Greater Chicago

Stop Smoking, American Lung Association in Illinois website

Smoking Cessation Fact Sheets and Materials

Smoking Cessation - National Institutes of Health

Smoking Cessation webpage

Smoking Q&A - National Cancer Institute

National Cancer Institute website

Smoking Cessation - American Heart Association

American Heart Association website

Smoking Cessation - National Institutes of Health

National Institutes of Health website

Tobacco Cessation Guideline – Surgeon General

Surgeon General webpage

Tobacco Fact Sheets – National Cancer Institute

National Cancer Institute website

Tobacco Cessation Patient Materials - American Academy of Family Physicians

American Academy of Family Physicians website

Freedom from Smoking Online – American Lung Association

American Lung Association website

The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014

The Health Consequences of Smoking webpage

Information for Women

National Partnership to Help Pregnant Smokers Quit

National Partnership to Help Pregnant Smokers Quit website

Tobacco Use and Pregnancy – Centers for Disease Control and Prevention

Centers for Disease Control and Prevention website

Information on Secondhand Smoke

Secondhand Smoke – American Cancer Society

American Cancer Society website

Secondhand Smoke Fact Sheet – American Lung Association

American Lung Association website

Smoke-Free Homes – U.S. Environmental Protection Agency

U.S Environmental Protection Agency webpage

Resources for Health Professionals

Five Major Steps to Intervention (The 5A's) – Agency for Healthcare Research and Quality

Agency for Healthcare Research and Quality webpage

Smoking Information for Health Professionals - American Cancer Society

American Cancer Society webpage

Counseling to Prevent Tobacco Use and Tobacco-Caused Diseases – Agency for Healthcare Research and Quality

Agency for Healthcare Research and Quality website

Guidelines for Smoking Cessation - Agency for Healthcare Quality and Research

- Agency for Healthcare Quality and Research website
 Smoking Cessation: Integration of Behavioral and Drug Therapies American
 Academy of Family Physicians
 - American Academy of Family Physicians website

Mental Health Screening and Referral Resources

General Information

Illinois children enrolled in the Department's Medical Programs are eligible for comprehensive mental health services, if medically indicated. The Department and the IDHS, Division of Mental Health, have collaborated to develop a system to ensure that children in need of mental health services will be appropriately referred and assessed for mental health treatment.

This appendix will assist the provider in completing the *Healthy Kids Mental Health Screen* form, the mental health portion of the Healthy Kids periodic screening. The *Mental Health Screen* is for use with children ages 3 through 20. There are recommended questions that will enable the provider to complete the *Healthy Kids Mental Health Screen*. Each of the questions is general in nature and is offered as an illustrative example of the information sought. It is suggested that the interviewer modify the question as indicated by the age of the child and understanding of the informant.

The questions should assist the evaluator in determining whether cognitive functioning/mental status is age-appropriate

- Whether behavior is appropriate (such as goal-directed with response to controls)
- Whether affect is appropriate

Previous mental health treatment should be recorded on the *Healthy Kids Mental Health Screen* form. The back of the *Healthy Kids Mental Health Screen* form contains a section relating to the child's medical history, which may impact mental health or emotional development.

Questions regarding maltreatment or possible maltreatment of the child should be addressed. For children over the age of three it is recommended that the maltreatment questions be asked of the child and their parents or caregiver separately.

It is important to note that the guidelines regarding maltreatment DO NOT suggest that in the event the provider/evaluator learns of, or suspects current maltreatment, that the provider is removed from professional responsibility for reporting abuse of neglect in lieu of making a referral to the Mental Health provider. **All suspected abuse or neglect should be immediately reported to:**

1-800-25ABUSE

When completing a referral to the Mental Health provider, please keep in mind that the provider's task is to identify behaviors and concerns that will assist the mental health professional in understanding the nature of the child's problem. Whenever the parent/caregiver, child or provider perceive a problem to be in existence and **outside a** "normal range" in extent or intensity, mark all behaviors/symptoms that apply.

Signs or symptoms may vary in severity, frequency, onset or duration; all of which are important issues in determining whether to refer or not.

The *Healthy Kids Mental Health Screen* (HFS 3411B) can be ordered by providers from the HFS Warehouse:

2946 Old Rochester Road Springfield, Illinois 62703-5659

All requests must be received on the HFS 1517 (R-9-06). This form may be obtained from HFS' Medical Forms webpage.

The form may be faxed to 1-217-557-6800.

Additional information about ordering Department forms can be found in *Chapter 100 - General Policy and Procedures, 112.43 Ordering of Claims Forms and Envelopes.*

Decision-making Regarding Mental Health Referrals

Sorting Out the Levels of Risk

In making a decision regarding referral, many of the symptoms/behaviors are significant enough to trigger an immediate referral. You will find these printed in **bold** on the checklist form. They include

- Suicidal Behavior or Suicidal Ideation
- Signs of Self Destructive Behavior
- Evidence of Abuse or Neglect Affecting Mental/Emotional Health
- Sexually Victimizes Others or Has Been Sexually Abused
- Victimization
- Evidence of Delusions or Hallucinations
- Appears Depressed or Hyperactive
- Demonstrates Signs of Eating or Sleeping Disorders
- Intentionally hurts other People or Animals
- Engages in fire setting
- Substance Abuse in Conjunction With Other Mental Health Concerns

The presence of any of these symptoms or behaviors may signal that the child is in crisis and are considered potent clinical indicators for possible referral to the appropriate mental health provider so that a mental health assessment, and if appropriate, mental health treatment may be obtained.

Children with other behaviors identified on the *Healthy Kids Mental Health Screen*, which in combination might indicate a mental or emotional disorder should be referred for a mental health assessment.

Referrals under the EPSDT program require that the provider:

- Obtain written consent of the parent/guardian to release information to the mental health service provider
- Make contact with an approved Mental Health Service Provider and set an appointment
- Communicate with the child and Parent/Guardian, the appointment time and location before they leave your office following the screening

- Send copies of your Mental Health Screen to the referral source
- Receive from the referral source within a reasonable amount of time (e.g. ten days following the appointment date) notification as to the disposition (show/no show) of the appointment, including any preliminary diagnosis and recommendations

The Mental Health Provider will, with the written permission of the parent/guardian:

- Receive the referral
- Notify physician if the appointment was not kept and has been re-scheduled. If the child has an identified case manager, the case manager should be notified for the purpose of follow-up
- Assess the client
- Provide continuing feedback to the referring physician as indicated (e.g., significant changes in the treatment plans, if hospitalized, referred for residential treatment, medication changes)

Healthy Kids Mental Health Screen

Recommended Questions to Assess Checklist Indicators (Ages 3 through 20)

In order to accurately complete the Healthy Kids Mental Health Screening form, the following simplified questions covering the specific areas of concern may be helpful to the screener. Although these are written questions to be asked of the parent/guardian, they can easily be adapted to first person for older children and adolescents. It is helpful to have the parent or child/adolescent provide examples (specific situations). Age appropriateness should be considered for all question asked.

Introductory Questions: Do you have concerns about this child? What concerns you most about this child? (These questions might give you an indication of what areas on the Mental Health Screen should be more closely explored.)

Thinking

- 1. **Delusions** Does your child: have "unusual" thoughts or behaviors that concern you or tend to be different from what most other children his age believes; believe that he has some unusual ability or power (not related to his age or developmental period)?
- 2. **Hallucinations** Does your child hear, see, taste, touch or smell things that are not really there?
- 3. **Paranoia** Is your child overly suspicious of others, or does he feel that others are out to get him?
- 4. Obsessive Ideation Does your child: seem to think about or talk about the same thing most of the time; seem to be preoccupied with things such as death, sex, bodily functions, extreme cleanliness, or other things that are unusual for someone his age.
- 5. **Frequent Memory Loss** Does your child often tend to forget things most other children his age would remember that is not related to discipline or punishment?

- 6. Confusion Does your child often seem to be confused, have difficulty following or understanding simple directions, or seem easily frustrated by instructions/directions?
- 7. **Easily Distracted** When your child is working on something, does your child have trouble staying on task? Is she/he bothered or distracted by sounds or things in his/her environment?
- 8. **Difficulty Concentrating** Does your child: often begin things and fail to finish them; have difficulty in finishing one thing prior to beginning another; move from activity to activity without apparent purpose?

Feeling

- 1. **Depressed Mood** (Sad) Does your child seem too often be irritable, depressed or sad? Has your child lost interest in things he used to enjoy?
- 2. **Inappropriate Affect** Does your child seem, without a reason, to often be happier and more energetic than most children his age or, be sad or angry when there seems no reason to be?
- 3. **Anxiety, Agitation** Does your child appear to be worried, frightened, nervous or upset easily or often?
- 4. **Anger** Is your child often easily angered or seem too often be mad?
- 5. **Apathy** Does your child show a lack of interest in things he once enjoyed? Describe onset.
- 6. **Low Self-Esteem** Does your child think he is less important, not as pretty or smart as other kids his/her age
- 7. **Self-Critical** Does your child say things that "puts himself down"?
- 8. **Cries Excessively** Does your child cry often over little things or for no apparent reason?
- 9. Cries too little Does your child not cry when you think he should?
- 10. **Emotionless**, **Flat Affect** Does your child fail to show feelings such as sadness, happiness or anger as often as other children his age?
- 11. **Feels Out of Control** Does your child act as though he is losing control of what he says, does or thinks? Does he say he fears losing control or "going crazy"?

Behavior

- Intentionally Hurts others Does your child seem to intentionally hurt others?
 How often? In what ways?
- 2. **Self-Destructive** Does your child intentionally do things to hurt himself? Does he often engage in dangerous or "risky" behaviors that might lead to injury or trouble? Have marks or bruises on herself that you suspect are self-inflicted?
- 3. **Intentionally Hurts Animals** Does your child do things to intentionally hurt animals?
- 4. **Sexually Victimizes Others** Has your child forced/made others do sexual things?
- 5. **Sets Fires** Does your child play with fire or been known to set fires? Explain.
- 6. **Compulsive Behavior** Does your child do the same thing repeatedly or not seem able to stop an activity or behavior once it is started?
- 7. **Destructive Behavior** Does your child destroy other people's things on purpose? His own things?

- 8. **Overreacts** Do little things bother your child to the point where he responds more strongly than other children?
- 9. **Overactive** Does your child appear to often have trouble sitting still when compared to other children his age?
- 10. **Listless** Does your child seem to easily lose interest or energy for doing things?
- 11. **Argumentative** Does your child often argue or disagree with others?
- 12. **Refuses to Talk** Does your child refuse to talk (or ignore people) when spoken to?

Social Interaction

1. Home Problems:

- a. Does your child have relationship problems with parents/guardians?
- b. Does your child have more problems with siblings than most children?
- c. Does your child have problems with others living in your house or other relatives?

2. Community Interaction:

- a. Has your child stolen on more than one occasion?
- b. Does your child lie often?
- c. Has your child come into contact with the police because of his behavior? Is he on probation, court supervision or parole?
- 3. **Defies Authority** Does your child have trouble getting along with people in authority (teachers, police, parents, etc.)?
- 4. **Friendless, Isolated** Does your child complain of not having friends, of others "picking on" him or does he play alone most of the time?
- 5. Immature Does your child often act like children of a much younger age?
- 6. **Excessive Clinging** Does your child show excessive fear when strangers are around? Refuse to stay with babysitters? Cling to you often?
- 7. **Withdrawn/Unresponsive** Does your child: prefer to play with things rather than people; ignore others even when spoken to? Have there been any recent changes in the way your child interacts with others including less involvement with others? Has your child's ability or willingness to communicate/talk with others changed recently?
- 8. **Inattentive** Does your child seem to ignore things taking place around him?

9. School Problems:

- a. Does your child have many fights at school?
- b. Is (has) your child failing in school? Are your child's grades much lower than he is capable of?
- c. Has your child been expelled/suspended from school for behavior?
- d. Is your child absent from school often? Does your child refuse to attend school? Does your child skip school (truancy)?
- e. Is your child in a special education class for behavioral or emotional problems?
- f. Does the child's age minus his grade equal 5 or 6? If not, does it indicate the child is below his normal grade level in school? If so, why?

<u>Age</u>		<u>Minus</u>	
		Grade Level	Grade Equivalent
10	-	6 =	4 (age appropriate)

10 - 2 = 8 (not age appropriate)

Physical Problems: Before checking any of these, the physician should rule out any physical disorders, which could account for the problem.

- 1. **Eating Disorders** Does your child do any of the following:
 - a. Refuse to eat often?
 - b. Often overeat?
 - c. Vomit often following a meal?
 - d. Have diarrhea often?
 - e. Complain often of stomachache?
- 2. Sleeping Disorders Does your child do any of the following:
 - a. Have difficulty falling asleep?
 - b. Have difficulty staying asleep?
 - c. Feel tired most every day?
 - d. Sleep walk?
 - e. Have bad dreams or nightmares frequently?
 - f. Cannot be awakened from a bad dream?
 - g. Snore a lot?
 - h. Move violently, jerk, twitch or grind teeth during the night?
- 3. Enuresis Does your child wet the bed at night or his clothing during the day?
- 4. Encopresis Does your child soil his pants in bed or during the day?
- 5. **Frequent Somatic Complaints** Does your child often complain of body pains or of being sick?
- 6. **Drastic Weight Change** Has your child gained or lost a lot of weight lately? (More than 10% of his body weight?)
- Lethargic Does your child appear to be often tired or have little energy?

The screener should provide comments for any item checked in this section in the Comment section on the backside of the form.

The following information may be obtained by interview or observation:

Life Changes (Stressors) (Last Year)

Victimized/Neglect – physical, sexual, financial (robbery, etc.), emotional, abuse or neglect (provide comments). Examples:

- Death of Family Member or close friend indicate relationship
- New School change of school (indicate number of changes in past three years)
- Loss of Relationship indicate relationship and cause
- Serious Illness/Injury of self or family member (indicate nature of illness or injury)
- Incarceration of Parent Parent or guardian placed in jail or prison
- Loss of Job self or family member (indicate impact on family)
- Economic Loss fire, accident, repossession, etc.
- Residence include foster placement, moves (indicate number)
- Witnessed a Violent Crime personally viewed the commission of a crime of violence or the injuries/death of the victim shortly thereafter or exposure to crime of violence in parent, caregiver or sibling?

Suicide Ideation

- 1. **Ideation/Plan** Is your child talking to you about ending his life, or wishing he were never alive or born, or about life being hopeless, of wanting to do serious self-harm? Does he talk about death often? Has your child ever spoken of a plan to kill himself? If so; how, when, and where has he indicated he will do it?
- 2. **Gestures** Have there been suicidal gestures (threats, notes, scratches on wrists, etc.) within the past year. Has your child done anything else that makes you think he seriously wants to end his life?
- 3. **Attempts** Have there been attempts (overdoses, hanging, etc.) that were unsuccessful anytime during his life? Has your child ever intentionally harmed himself?

The screener should comment on any suicidal indications in the Comment section on the back of the form.

Substance Abuse

Do you suspect your child has experimented with drugs or alcohol? What makes you think that? What drugs and alcohol usage has occurred, if any? Indicate types, amounts and frequency.

Medical Issues

Is there a significant illness or injury in the child's medical history that you feel affects his mental/emotional health? (Indicate medical diagnoses, current medications, hospitalizations, major illnesses, surgeries, severe injuries, significant developmental delays, out-of-home placements and significant family crises.)

Abuse/Neglect

Is there anything that causes you to suspect child abuse or neglect? (SPECIFY) **Report immediately 1-800-25-ABUSE**

Child

Screener

HK-10

Healthy Kids Mental Health Screening Tool Ages 3 Through 20 Illinois Department of Healthcare and Family Services

Parent/Caregiver

Name Birth Date Age Grade Medicaid No	Name Address Phone	Name Physician Clinic Address Phone
Based on age appropriateness instructed. Make a referral for Provider Handbook for instruction is currently receiving treatments.	nild, parent/guardian, and check s, mark those that are currently in a Mental Health Assessment what tions.) STOP! If the child has a nent do not continue. Out this child? What about this continue.	indicated unless otherwise nen necessary. (Refer to Ilready been referred or
ThinkingDelusionsHallucinationsParanoiaObsessive Ideation	OveractiveListlessArgumentativeRefuses to TalkNone of the Above	New SchoolLost RelationshipSerious Illness/InjuryIncarceration of a Parent
Frequent Memory LossConfusionEasily DistractedDifficulty Concentrating None of the Above	FeelingDepressed Mood (Sad or irritable)Inappropriate AffectAnxiety, AgitationAnger	Loss of JobEconomic LossResidenceWitnessed a Violent CrimeNone of the Above
BehaviorIntentionally Hurts OthersSelf-DestructiveIntentionally Hurts AnimalsSexually Victimizes OthersSets Fires	ApathyLow Self-EsteemSelf-CriticalCries ExcessivelyCries Too LittleEmotionless, Flat AffectFeels Out of ControlNone of the Above	Physical (Rule out physical disorder) Eating Disorder (Specify) Sleep Disorder (Specify) Enuresis Encopresis Frequent Somatic Complaints
Compulsive BehaviorsDestructive Behaviors Overreacts	Life Changes (past year)Victimized/NeglectDeath of Family Member	Drastic Weight ChangeLethargicNone of the Above

	ls Services	Chapter HK-200 – Appen
	Friendless, Isolated	Heart Condition
	Immature	Asthma
Suicide Assessment	Excessive Clinging	Tuberculosis
(N/A)	Withdrawn/	Urinary Tract
Ideation/ Plan	Unresponsive	Condition
(current)	Inattentive	Anemia
Gestures (past	School Problems	Cancer
year)	Excessive	G.I. Condition
Attempts (during	Fighting	Other (specify)
lifetime)	Failure, Grades	
mounto)	Expulsion	Health History
Comment on back for	Zxpaision Truancy	Major Surgery
any item checked	Special Ed.	(specify)
under Physical or	(Behavior/	Head Injury
Suicide.	Emotional	(medically
Galolac.	Problems)	evaluated)
Substance Abuse	Child's Age	Other Injury
(N/A)	(Minus) Grade = 5 or 6	Medical
Drug of Choice	None of the Above	Hospitalization
Amount	None of the Above	(past 3 years)
Frequency	Medical Issues: Mark	(past o years)
	any of the following that	Family Situation
Social	are applicable.	Out of Home
Problems at home	are approadic.	Placement
Parents	Has the child ever or do	Family History of
Siblings	they currently have any	Mental Illness
Others	of the following:	Family History of
Community	or the reme thing.	Substance Abuse
Interaction	(Provide narrative under	Child or Family
Stealing	comments)	Received
	,	Counseling (past
Chronic Lyina		
Chronic Lying Police Involved	Chronic Conditions	years)

Note: Bolded items may require an immediate referral.

___CHECK IF PARENT OR GUARDIAN REQUESTS A REFERRAL.

Suspected Child **Abuse** and **Neglect** must be reported to DCFS immediately! **1-800-25ABUSE.**

The Physician conducting the Healthy Kids Mental Health Screen:

- 1. Makes an appointment with a Mental Health provider when indicated. The appointment should be made while the child is at your office and the information about the appointment should be given to the parent/caregiver.
- 2. Sends a copy of this form to the Mental Health provider.

REFERI	RAL TO
DATE _	TIME
DATE C	LIENT NOTIFIED OF APPOINTMENT
BY WHO	DM
consent 1. S b 2. Ir 3. R	ntal Health Provider conducting the mental health assessment, with the signed of the parent/guardian: ends a copy of this form to the referring physician once the assessment has een completed indicating recommended services. If orms the referring physician of the missed or rescheduled appointments. eports the client's progress, change in treatment plans on a quarterly basis until ase closure.
To be co physicia	ompleted by the Mental Health Provider Only and returned to the referring n.
Date of	Assessment
Diagnos	is

Recommended Services:

Substance Abuse Screening and Referral Resources

Substance Abuse Screen Instructions

The screen can be administered by virtually anyone who knows the patient, like the parent or another significant person in the patient's life; or a person who has a professional relationship with the patient, such as a nurse or other physician's office personnel. The screen is **not** a diagnostic tool. Rather it provides a way to capture some vital information that can be used to either confirm, or dispel, the possibility of a substance abuse problem with the young person under consideration.

With the exception of the items in **bold print**, no single response has much meaning in, and of, itself. It is a series of responses that present a pattern, no matter how slight, of attitudes and behaviors, which lead the screener to feel that more information is needed. The screening process will not confirm the existence of a substance abuse problem, but it will give sufficient support for a recommendation that the client see a substance abuse professional for a formal, clinical evaluation.

It is important for the screener to remember that the earlier a problem is identified, the earlier a serious intervention can begin. Substance abuse that is caught early is very treatable. Like most diseases, however, if left untreated, the costs, both personal and financial, grow considerably.

Guidelines to Each Section

Thinking: How the patient processes information is the focus of this section. Everyone will get confused at times and at times, forget things. That is normal. What is being assessed is a pattern of thought processes that are significantly different from other young people. In other words, does the patient usually process information normally, or is he/she usually confused, distracted, and disoriented?

Life Style Changes: No single item means a problem in isolation. If a pattern of responses is noted however, the screener should begin to consider the possibility of dysfunctional living. Combinations of these elements present a set of characteristics that are common to many youthful substance abusers.

Temperament: There is no need to be concerned with the occasional or sporadic flash of temper. All young people get frustrated from time to time and that frustration often takes the form of anger or a negative attitude. In this section, the screener is trying to find out if the young person shows these negative behaviors or attitudes represent a change from the way the patient used to be. Many times this will be noted when a parent says something like "I just don't know what's the matter with him/her anymore. He/She used to be such a nice boy/girl."

Social: This is the area that the patient and the family often have the hardest time talking about. Many things influence the environment in which the patient lives. If those environmental factors reflect negatively on the parents, they do not surface easily. For example, if the parents are problem drinkers, or if they do drugs themselves, it will be

difficult for them to admit that their behavior has a negative impact on the rest of the family. Also, as young people mature, their peer relationships change. This is normal. However, if the young patient now rejects, or is rejected by the friends he/she once had and if the new friends tend to be secretive or reluctant to share what they do with others, especially with adults, it might indicate that the patient's new constellation of friends belong to the marginal sub-culture associated with drug use. With young people, the old adage that, "you are known by the friends you keep," is very accurate. Again, in this section, the screener is looking for abrupt change and for patterns of signs and symptoms. Any one of the items by itself has little, if any, significance.

Behavior: This section deals with elements that are the most obvious, and the behaviors noted here are the ones most commonly associated with a young person who is attempting to deal with a problem of some type. Those attempts may, or may not, involve drug use. Or, drug use itself may be the problem. Finding out, which came first is not important at this point. The important thing is to note that all of these behaviors tend to be negative and a pattern of even a couple of them is an excellent indicator that some kind of professional involvement is called for. If drug use can be ruled out early, other appropriate help can be provided. If the professional finds substance abuse at this early stage, however, a lot of critical time has been saved and the appropriate treatment can begin sooner, rather than later.

Substance Abuse: Any checked item in this section is an automatic "trigger" to make a referral for a formal, clinical assessment by a substance abuse professional. If the screener notes even one of these examples, the case should be referred for professional interventions. In conclusion, the screener can either write up a brief summary for the physician, or the completed screen can simply be given, without comment, to the doctor for evaluation. In any event, the physician will determine the next step in the patient's care. If a referral is made, the Primary Care Provider, or case manager, if the patient has been assigned one, should see to it that the patient keeps the appointment for a clinical assessment by the substance abuse professional.

Substance Abuse Pre-Assessment Screen

Use and Referral Process

Instructions

To make a referral for clinical assessment of a suspected problem with alcohol or other drug abuse, please administer the attached pre-assessment screen to the patient. The screen is in a simple checklist format and it can be administered by virtually anyone.

When the screen has been completed, review the results. If, in the provider's professional opinion, there is reason to SUSPECT the presence of a substance abuse problem, refer that patient to a substance abuse professional for a clinical assessment. Once completed, that assessment will be returned to the provider for inclusion in the provider's comprehensive evaluation of the patient and patient's confidential medical record.

Decision-Making Regarding Substance Abuse Referrals

Sorting Out the Levels of Risk

Referrals under the EPSDT program require that the physician/provider:

- Obtain written consent of the patient to release information to the substance abuse treatment provider
- Make contact with an approved substance abuse treatment services provider to arrange an appointment
- Communicate with the patient and parent, the appointment time and location before they leave the provider's office following the screening
- Send copies of your Substance Abuse Treatment Screen to the referral source
- Receive from the referral source within a reasonable amount of time (e.g. ten
 days following the appointment date) notification as to the disposition (show/no
 show) of the appointment, including any diagnosis and recommendations

The substance abuse treatment provider will, with the written permission of the parent: Receive the referral

- Notify the physician if the appointment was not kept and has been re-scheduled. If the patient has an identified case manager, the case manager should be notified for the purpose of follow-up.
- Assess the patient
- Provide continuing feedback to the referring physician as indicated (e.g. significant changes in the treatment plans)

Contact Points for Substance Abuse Treatment Services

To arrange for a pre-assessment screening to identify the presence of a substance abuse problem, or to schedule a formal, clinical assessment of your patient by a certified substance abuse professional, please contact an appropriate agency or program.

The Substance Abuse Screening Instrument (HFS 3411D) can be ordered by providers from:

HFS Warehouse 2946 Old Rochester Road Springfield, IL 62703-5659

All requests must be received on the HFS 1517 (R-9-06). This form may be obtained from HFS' Medical Forms webpage.

The form may be faxed to 1-217-557-6800.

Additional information about ordering Department forms can be found in *Chapter 100 - General Policy and Procedures, 112.43 Ordering of Claims Forms and Envelopes.*

Healthy Kids Substance Abuse Screen Illinois Department of Healthcare and Family Services Bureau of Maternal and Child Health Promotion

I. Patient	
Name	
Medicaid Number	
Birth Date	
Age	
Grade	
II. Parent	III. Screener
Name	Name
	Physician
Address	Clinic
	Address
Phone	Phone
currently receiving treatment for substance Thinking	Involvement in Gang or
Frequent Memory Loss	Gang Activity
Confusion	Temperament
Easily Distracted	Tomporamone
Difficulty Concentrating	Overly Defensive
,	Quick to anger
Life Style Changes	Listless, Uninterested
	Argumentative
Change in Group of Friends	Cocky, Arrogant
Poor Personal HygieneUnkempt Appearance	"Spaced Out" Much of the Time
Drug Oriented Language	Social
Erratic Sleep Patterns	333.41
Poor Eating Habits	Problems at Home
Unfulfilled Promises	Substance Abuse at Home
Excessive Interest in "Hard Rock"	Problems with Neighbors
Music (Heavy Metal,Acid)	
Cult Activities	Loss of Former Friends

ndbook for Providers of Healthy Kids Services	Chapter HK-200 – Appendices	
Disliked by Significant Other Evidence Peers are Drug Involved Evidence of Low Self-Esteem	Suicidal, Ideation of Attempt Avoidance of Parents, Family Members, Authority Figures, Adults Severe Mood Swings	
	Substance Abuse	
Behavior	Obviously Interiorted at Times	
Increase in Secretive BehaviorCruel (Hurts Others)Self Hurt (Mutilation, Tattoos)Hurts AnimalsOver Reacts/Under ReactsDefiant of AuthorityExcuses, Lies	 Obviously Intoxicated at Times Possession of Drug Paraphernalia "Glassy" Eyes Blackouts Signs of IV Drug Use Signs of Nasal Damage from Inhalation, Sniffing or "Snorting" Other Evidence of Drug Use 	
HFS 3411D (N-5-93)		
Substance Abuse Treatment during the p	st three yearspatientfamily member east three yearspatientfamily	
member. List other Medical Conditions that may im	pact social or emotional development.	
Is the patient currently on Medication ? If so	o, specify medications and dosages:	
Comments (Substance Abuse):		
Check if Parent Requests a Referral.		
Suspected Child Abuse and Neglect must be reported to DCFS immediately!		

1-800-25ABUSE

Recommended Services:

The **Physician** conducting the Healthy Kids Substance Abuse Screen:

- Makes an appointment with a substance abuse treatment provider when indicated while the patient is at your office and the information about the appointment should be given to the parent
- Sends a copy of this form to the substance abuse treatment provider

eferral To
ateTime
ate Client Notified Of Appointment
y Whom
he Substance Abuse Provider conducting the substance abuse assessment, with the igned consent of the parent: Sends a copy of this form to the referring physician once the assessment has been completed indicating recommended services Informs the referring physician of the missed or rescheduled appointments Reports the patient's progress or change in treatment plans on a quarterly basis until case closure
o be completed by the Substance Abuse Provider Only and returned to the referring hysician.
ate of Assessment
iagnosis

Perinatal Depression Resources

DHS provides partial funding to support a 24-hour Perinatal Hotline at NorthShore Hospital. Any person who desires more information about Perinatal Mental Health Disorder may use this Hotline to obtain general education, referral information, or provider support.

Provider support:

■ Phone: 1-866-364-MOMS (1-866-364-6667)

Patients may also get referrals through the **DHS Helpline**:

Phone: 1-800-843-6154TTY: 1-800-447-6404

Providers can access additional information about perinatal and postpartum depression referral resources on HFS' Maternal and Child Health webpage.

<u>HFS' Support Groups for Perinatal Depression webpage</u> includes a search function to identify support groups, inpatient and outpatient services that are available statewide by county. There are also listings of resources for supportive services for women suffering from perinatal depression.

HK- 14
Procedure Codes for Approved Risk Assessment Tools

Procedure Description	Recommended CPT Code
Risk Assessment	
Problem-Oriented Screening Instrument for Teenagers (POSIT)	99420
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	99420
Child and Adolescent Depression	
Beck Depression Inventory-II (BDI-II)	99420
Center for Epidemiological Studies Depression Scale (CES-D)	99420
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	99420
Patient Health Questionnaire Adolescent Version (PHQ-A)	99420
Patient Health Questionnaire Quick Depression Screen (PHQ-9)	99420
Children's Depression Inventory (CDI)	99420
Reynolds Adolescent Depression Scale (RADS)	99420
Pediatric Symptom Checklist	99420
Maternal Depression	
Administration and interpretation of health risk assessment (Postpartum Depression Screening)	99420 HD
Prenatal care, at risk assessment	H1000
(Prenatal Depression Screening)	
Edinburgh Postpartum Depression Scale (EPDS)	99420 HD
Beck Depression Inventory-II (BDI-II)	99420
Center for Epidemiological Studies Depression Scale (CES-D)	99420
Patient Health Questionnaire Quick Depression Screen (PHQ-9)	99420
Parenting Stress Index (PSI)	99420
Adolescent Alcohol and Substance Use and Abuse	
Problem-Oriented Screening Instrument for Teenagers (POSIT)	99420
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) Screening Tool	99420

The GAPS Screening Tool is not an approved risk assessment as it is no longer supported by the American Medical Association (AMA) and is not publicly available.

Developmental Milestones

Note: The developmental milestones below are recommended as minimal to be assessed through surveillance, observation, and inquiry/discussions with parent(s), guardian(s), and caretaker(s). For more information on developmental milestones, visit the following resources:

AAP's Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition (2008)

AAP's Bright Futures website

CDC "Learn the Signs. Act Early." campaign and resources

CDC "Learn the Signs. Act Early website

Healthy Steps for Young Children Program

Healthy Steps for Young Children Program website

2-4 WEEKS:

Physical

- Raises head momentarily when prone
- Fixes on human face or brightly colored toys and follows with eyes
- Has flexed posture; moves all extremities
- Grasps an adult finger

Social-Emotional

- Responds to parent's face and voice
- Smiles spontaneously
- Turns head in direction of parent's voice
- Tries to self-comfort by sucking on one or more fingers
- Can sleep for three or four hours at a time; can stay awake for one hour

Communication – Hearing and Vision

- Responds to sound by blinking; crying; quieting; changing respiration; or showing startle response
- Can be consoled most of the time by being spoken to or held
- Cry to indicate hunger or discomfort

2 Months:

Physical

- Grasps rattle placed in hand
- When prone (only when awake due to SIDS precaution), lifts head, neck and upper chest with support of forearms
- Some head control in upright position

Social-Emotional

- Makes eye contact
- Social smiles; smiles responsively
- Coos and reciprocal vocalization when spoken to

Demonstrates social interaction; follows moving person with eyes

Communication - Hearing, Vision, Language

 Shows interest in visual and auditory stimuli – will turn toward things that look and/or sound interesting

4 Months:

Physical

- Holds head high, raises body on hands when prone
- Sits when supported
- Controls head well
- Stands when pulled upright
- Plays with hands, holds rattle, reaches for objects, holds own hands

Social-Emotional

- Smiles spontaneously
- Coos, laughs, babbles
- Demonstrates range of emotions
- Initiates social contact, turns to voice
- May sleep at least six hours
- Able to comfort self, e.g., fall asleep by self
- More expressive communicates more with face and body

Communication - Hearing, Vision, Language

- Looks at mobile, arms active
- Follows object 180 degrees
- Uses vowel and consonant sounds such as "dada" and "baba"

6 Months:

Physical

- Rolls both ways
- Sits with support
- Bears weight, stands with support
- Transfers objects hand-to-hand
- Shakes head
- Points finger
- Creeps or scoots on bottom

Social-Emotional

- May show stranger anxiety
- Reacts socially by smiling in response to someone else's smile
- Shows recognition of parents
- Shows interest in toys
- Starts to self-feed

Communication - Hearing, Vision, Language

- Turns to sound and voice
- Vocalizes single consonants ("dada", "baba")
- May imitate sounds of speech
- Babbles reciprocally

Cognitive

Raking hand pattern

- Grasps and mouths objects
- Shakes, bangs, and drops a toy

9 Months:

Physical

- Sits independently
- Reaches for objects with one hand
- Pulls to stand
- Stands holding on
- Inferior pincer grasp, pokes with index finger
- Bangs, throws and drops objects

Social-Emotional

- Finger feeds
- Starts to use cup
- Can sleep through the night
- Reaches for a familiar person and responds to others expressions of emotion
- May show stranger anxiety
- Enjoys interactive social games, e.g., peek-a-boo and pat-a-cake
- Interested in mirror images

Communication - Hearing, Vision, Language

- Imitates vocalizations, babbles
- May say "dada" and "mama" nonspecifically
- Responds to own name
- Understands a few words, e.g., "no-no"; "bye-bye"
- Turns towards sound with eyes and head movement
- Babbles string of consonant; vowel and "sentences"

Cognitive

- Follows a point
- Wave bye-bye
- Finds a hidden object
- Explores with hands and mouth

12 Months:

Physical

- Gets from sitting to crawling position
- Pulls to stand
- Stands alone
- Cruises
- May take a few steps alone
- Has precise pincer grasp
- Bangs two blocks together
- Tries to scribble with pencil on paper
- Takes objects in and out of container can let go voluntarily

Social-Emotional

- Recognizes caregiver's voice
- Obeys simple requests, waves "bye-bye"
- Feeds self

- Drinks from a cup
- Shows emotions (fear, anxiety, affection)
- Shy or anxious with strangers
- Cries when mother or father leaves
- Shows preference for certain people or toys
- Prefers mother and/or regular caregiver over all others
- Extends arm or leg when being dressed
- Tests parental response to behavior
- Repeats sounds and gestures for attention
- Imitates enjoys imitating people in his play

Communication - Hearing, Vision, Language

- Points or gestures to indicates wants or get needs met
- Has vocabulary of one to three words
- Uses "mama" and "dada" correctly
- Full color vision
- Distance vision matures
- Ability to track moving object
- Say 1-3 words in addition to "mama" "dada"
- Points with index finger
- Stops eating and starts playing when full
- Responds to simple verbal requests
- Responds to "no"
- Babbles with inflection
- Understands simple command
- Says "oh-oh"

Cognitive

- Actively look for hidden or dropped objects
- Struggles to obtain object out of reach
- Looks at correct picture when image is named
- Imitates household activities
- Stacks two blocks

15 Months:

Physical

- Walks alone, bends over, may run
- Crawls up stairs
- Points to one or more body parts
- Feeds self with fingers, drinks from cup

Social-Emotional

- Listens to a story
- Checks parent facial expression
- Begins to show empathy
- Fears new things including new foods
- Responds to encouragement to eat even when full to please adult

Communication – Hearing, Vision, Language

- Has vocabulary of three to ten words
- Indicates wants by pointing or grunting
- Points to indicate to another object of interest

- Temper tantrums out of frustration
- Refuses to eat when not hungry

Cognitive

- Stacks 2-3 blocks
- Points to one or more body parts
- Can remove some clothing
- Understands cause and effect and problem solves
- Uses symbolic play
- Imitates social games

18 Months:

Physical

- Likes to climb and run
- Walks quickly or runs stiffly
- Walks backwards
- Climbs into chair
- Sits in chair
- Throws/kicks ball
- Stacks three or four blocks
- Eats with utensils
- Drinks from cup
- Brushes teeth with assistance
- Washes and dries hands with assistance

Social-Emotional

- Uses a spoon and cup
- Shows affection by hug and kisses
- Wants comfort item in bed, e.g., doll; blanket
- Attracts parental attention by looks and gestures
- Plays cooperatively for brief sessions
- Plays pretend
- Clinging to parent returns
- Enjoys looking at self in mirror

Communication – Hearing, Vision, Language

- Has a vocabulary of 15-20 words; uses two word phrases; imitates words
- Listens to a story; looks at pictures; names objects
- Answers simple questions by pointing
- Follows simple directions/rules
- Names one picture
- Names two colors
- Points to four pictures
- Uses two to three word sentences
- Savs 15-20 words
- Uses two-word phrases

- Plays with toys appropriately, e.g., pulls a pull toy; cuddles a doll
- Scribbles spontaneously; imitates crayon strokes
- Dumps object from bottle without demonstration
- Helps dress self

- Places circle; square shapes in a puzzle
- Stacks 4-6 blocks
- Zips and unzips
- Points to some body parts

24 Months:

Physical

- Up and down steps holding on with one hand; one step at a time
- Climbs onto and down from furniture unassisted
- Jumps; runs
- Throws ball overhand
- Stands on one foot with little support
- Puts on clothing; undress self
- Washes hands
- Strings beads
- Builds a tower of 6-8 blocks
- Shows handedness
- Helps prepare food, e.g., scrub; tear; break; dip; snap
- Begins to show signs of toilet training readiness
- Turns pages of book one at a time

Social-Emotional

- Parallel play dominant
- Possessive with toys
- Separation anxiety from parents
- Cooperative (sometimes)
- Plays with joy
- Spontaneously shows sense of humor
- Enjoys playing next to other children
- Offers a toy
- Responds to encouragement to eat to please adult
- Explores independently with confidence

Communication - Hearing, Vision, Language

- Vocabulary 20-50+ words
- Speaks 2-4 word sentences that include verbs, adjectives, and adverbs
- Understands pronouns
- Speech should be intelligible to parents
- Can follow two-step commands
- Can name some body parts
- Dawdles when not hungry

Cognitive

- Makes or imitates horizontal and circular strokes with crayon
- Imitates adults
- Increasing attention span

3 Years:

Physical

Balances on one foot for 2 seconds

- Rides a tricycle, with or without training wheels
- Alternates feet ascending stairs
- Copies a circle and a cross
- Pours liquids
- Uses a fork
- Serves food from a bowl using child size utensils
- Toilet trained
- Uses a blunt scissors
- Dresses and undresses self (may need help with fastening)

Social-Emotional

- Can follow directions
- Pretend play well developed (imagines self as a character; uses toys as props)
- Has words for feelings
- Shows empathy
- Approach and play with familiar children
- Plays well with others
- Understands concept of "mine" and "his/hers"
- Begins to share toys
- Takes turns
- Talks for objects
- Responds to encouragement to eat even when full to please adult
- Separates easily from parents
- Objects to major changes in routine

Communication – Hearing, Vision, Language

- Demonstrates speech that is mostly intelligible
- Plays show and tell
- Uses three word sentences
- Talks clearly and is understandable most of time
- Says at least 250 words
- Knows all pronouns

- Copies circle and cross
- Visually discriminates colors
- Matches colors and sorts by category, shape
- Names colors
- Identifies food by name
- Asks "why" questions
- Has some self care skills, e.g., feeding and dressing self
- Understands concept of "two"
- Count to five
- Talks about the future
- Knows name, age and gender
- Uses own name and others
- Gender identity established
- Names six body parts
- Name missing object
- Makes mechanical toys work
- Completes a 3-4 piece puzzle

4 Years:

Physical

- Hops, jumps forward
- Runs easily
- Alternates feet when climbing stairs
- Balances on each foot for five seconds
- Climbs
- Builds tower of 10 or more blocks
- Throws overhand
- Ability to cut and paste
- Peels, cuts, mashes and rolls food
- Holds pencil in writing position
- Begins to copy some capital letters
- Screws and unscrews jars, nuts and bolts
- Turns rotating handle

Social-Emotional

- Plays board/card games
- Can talk about daily activities and experiences
- Often cannot distinguish fantasy from reality
- Imagines that many unfamiliar images may be "monsters"
- Make believe play; imaginary playmates
- Puts away own toys
- Dresses and undresses self buttons
- Brushes teeth without assistance
- Cooperative play with group
- More independent
- Play "mom" or "dad"
- Negotiates solutions to conflicts
- Views self as a whole person involving body, mind, and feelings

Communication - Hearing, Vision, Language

- Sings a song
- Speaks in sentences of five to six words
- Speaks clearly enough for strangers to understand
- Tells stories
- Talking gets in the way of eating (prefers to talk)
- Has mastered some basic rules of grammar

- Gives first and last name
- Draws a three part person
- Says a poem
- Strong food preferences
- Relates health to own body
- Understands right and wrong based on consequences not intentions
- Copies a square
- Draws circles and squares
- Correctly names some colors
- Begins to have clear sense of time
- Follows a three-part command

- Understands the concept of "same" and "different"
- Engages in fantasy play

5 Years:

Physical

- Dresses and undresses self without assistance
- Ties shoelaces
- Heel-to-toe walk
- Walks downstairs, using alternative feet
- Hops on one foot
- Begins to skip alternating feet
- Swings
- Can use scissors to cut a straight line
- Traces within lines
- Draws a person with body
- Prints some letters
- Uses fork, spoon, and sometime table knife
- Copies triangle and other shapes
- Can handle snaps, buckles, buttons, zippers; begins to tie shoes
- Independent toileting

Social-Emotional

- Plays make believe and dress up
- Plays and shares with others
- Wants to please friends
- More likely to agree on rules
- Likes to sing, dance, and act
- Shows more independence
- Able to function in structured group with rules
- Shows concern and sympathy for others
- Initiates sharing and taking turns
- Aware of gender
- Able to distinguish fantasy from reality
- Sometime demanding; sometimes eagerly cooperative

Communication - Hearing, Vision, Language

- Speaks in sentences of more than five words phrases that are understood by others
- Understands opposites
- Recalls parts of stories, tells longer stories
- Asks meaning of words
- Describes pictures and experiences
- Uses appropriate verb tense and grammar
- Recognizes simple jokes, riddles, absurdities (Do cats fly?)

- Knows own address and phone number
- Recognizes four colors and common shapes
- Copies simple shapes (e.g., triangle or square)
- Prints a few letters and numbers
- Draws a person with head, body, arm and legs

- Counts on fingers or ten or more objects
- Better understands the concept of time
- Knows about things used in home (money, food, appliances)

Kindergarten Checklist

There is no simple method for determining that a child is ready for kindergarten. But this list from a child development specialist may help parents evaluate their children's developmental level. These developmental skills are important for a child if he is to function happily in the kindergarten classroom.

Speech and language:

- Asks meaning of words
- Describes pictures and experiences
- Uses appropriate verb tense and grammar
- Recognizes simple jokes, riddles, absurdities (Do cats fly?)

Gross motor coordination:

- Walks downstairs, using alternative feet
- Hops on one foot
- Jumps along a 6-foot line with both feet
- Walks scissor steps across a line
- Begins to skip alternating feet

Fine motor coordination:

- Can use scissors to cut a straight line
- Copies a circle square and cross
- Draws a person fully with body and four limbs
- Traces within lines

Social and emotional:

- Can handle snaps, buckles, buttons, zippers and begins to tie shoes
- Independent toileting; dresses and undresses independently
- Able to function in structured group with rules
- Shows concern and sympathy for others
- Initiates sharing and taking turns

Procedure Codes for Approved Developmental Screening Tools

Developmental assessment tools may be updated to reflect new advances. Updates to tools listed below are approved for reimbursement by HFS. However, HFS reserves the right to periodically review updates to previously approved tools to assure they continue to meet the reimbursement approval criteria. If the updated iteration does not meet the criteria, HFS can deny approval for reimbursement for the updated tool. HFS will post the rescission of approval on our website at least 180 days prior to initiation of denials.

As a best practice strategy, use of a social-emotional screening instrument is recommended.

Tier 1: Developmental Screening and Assessment/Evaluation Tools	Recommended
- Approved for Reimbursement	CPT Code
Procedure Description: Developmental Screening Tools	96110
Ages and Stages Questionnaires (ASQ)	96110
Ages & Stages Questionnaire 3rd Edition (ASQ-3)	96110
Ages & Stages Questionnaires: Social-Emotional (ASQ : SE)	96110
Battelle Developmental Inventory Screening Test (BDIST)	96110
Bayley Infant Neurodevelopment Screener (BINS)	96110
Bayley Scales of Infant and Toddler Development 3 rd Edition (Bayley-III) –	96110
Screening Test	
Brief Infant Toddler Social and Emotional Assessment (BITSEA)	96110
Brigance Early Childhood Screens (0-35 Months, 3-5 Years, K&1)	96110
Chicago Early Developmental Screening Inventory	96110
Developmental Profile II	96110
Developmental Indicators for the Assessment of Learning – Revised	96110
(DIAL-R)	
Developmental Indicators for the Assessment of Learning – 3 rd Edition	96110
(DIAL-3)	
Early Language Milestone Scales Screen	96110
Early Screening Inventory (ESI)	96110
Early Screening Profiles (ESP)	96110
Eyberg Child Behavior Inventory/Sutter-Eyberg Student Behavior	96110
Family Psychosocial Screening	96110
Infant Development Inventory (IDI)	96110
Infant -Toddler Checklist for Language and Communication	96110
Infant-Toddler Symptoms Checklist	96110
McCarthy Screening Test (MST)	96110
Modified Checklist for Autism in Toddlers (M-CHAT)	96110
Minneapolis Preschool Screening Instrument (MPSI)	96110

Parent's Evaluation of Developmental Status (PEDS)	96110
Parent's Evaluation of Developmental Status- Developmental Milestones	96110
(PEDS:DM)	
Parents' Observation of Infants and Toddlers (POINT)	96110
Pediatric Symptom Checklist (PSC)	96110
Project Memphis DST	96110
Revised Developmental Screening Inventory	96110
Revised Parent Developmental Questionnaire	96110
Safety Word Inventory and Literacy Screener (SWILS)	96110
Temperament and Atypical Behavior Scale (TABS) Screener	96110
Procedure Description: Developmental Assessment/Evaluation	96111
Tools	
Achenbach Child Behavior Checklist – Preschool Module (ASEBA)	96111
Battelle Developmental Inventory (BDI)	96111
Bayley Scales of Infant and Toddler Development III	96111
Brigance Inventory of Early Development III Standardized (IED III)	96111
Child Development Inventory (CDI)	96111
Connor's Rating Scales (CRS)	96111
Developmental Assessment of Young Children (DAYC)	96111
Devereux Early Childhood – Clinical Form	96111
Devereux Early Childhood Assessment for Infants and Toddlers	96111
Early Coping Inventory	96111
Erhardt Development Prehension Assessment (EDPA)	96111
Hawaii Early Learning Profile (HELP)	96111
Infant Toddler Developmental Assessment (IDA)	96111
Infant-Toddler Social and Emotional Assessment (ITSEA)	96111
Otis-Lennon School Ability Test (OLSAT)	96111
Piers-Harris Children's Self-Concept Scale (PHCSCS)	96111
Temperament and Atypical Behavior Scale (TABS) Assessment Tool	96111
Vineland Adaptive Behavior Scales (VABS)	96111
Vineland Social-Emotional Early Childhood Scales (Vineland SEEC)	96111
Vineland Social Maturity Scale	96111

Please note, the following Tier 2 tool(s) were removed from the Tier 1 approved list. To allow time for transition, providers have 12 months following the removal date to continue using the tool. Thereafter, providers must not submit claims for reimbursement based on use of unapproved tools.

Tier 2: Developmental Screening Tools – Removed from Tier 1 Approved List	Removal Date	HFS Reimbursement Ends
Denver DST/Denver II	Publication date of	12 months after
	the revised Healthy	publication date of
	Kids Handbook	revised Healthy Kids
		Handbook
Developmental Assessment/Evaluation		
Tools – Removed from Tier 1 Approved		
List		
N/A		

Early Intervention Program and Other Developmental Resources **Illinois Department of Human Services**

For Early Intervention address information see the **DHS Early Intervention webpage**. To order Public Awareness materials call 1-800-851-6197.

Children's Services Directory

Phone/TTY: 1-800-323-4769

Provides information about the early intervention system, including access to a variety of public awareness/educational materials, and refers people to early intervention programs and service coordinators in their area. English and Spanish speaking counselors are available to answer calls.

Illinois Early Childhood Intervention Clearinghouse

■ Phone/TTY: 1-800-852-4302

Loans books, videos and other materials on early childhood development (in English and Spanish) free of charge. The Clearinghouse also publishes a quarterly newsletter called Early Intervention.

Illinois Network of Child Care Resource and Referral Agencies

Phone: 1-800-649-1884

> Represents child care providers in 16 service delivery areas (SDAs) throughout the state, providing training and services for child care centers and family child care programs. Each SDA has a team of inclusion leaders and/or local resources to help providers working with special needs children.

Illinois Assistive Technology Project

■ Phone/TTY: 1-800-852-5110

Provides information about adaptive equipment for all ages.

Illinois STAR NET (Support and Technical Assistance Regionally)

Regions I and III 1-309-298-1634 or 1-800-227-7537

Region II 1-847-803-3565 Region IV 1-618-397-8930 Region V 1-773-535-8470 Region VI 1-708-342-5370

(See the STARNET website for a map of regions)

Provides training and technical assistance, including workshops, satellite distance education, consultation, fellowships and materials to early intervention and preschool staff and families of young children ages birth to 5 who have special needs.

The Autism Program of Illinois (TAP)

Website: The Hope Institute in Springfield, Illinois

Phone: 1-217-525-8332

Website: Phone: Illinois State University at Bloomington-Normal

1-217-244-1395

Website: Southern Illinois University at Carbondale

Phone: 1-618-536-2122

Website: <u>University of Illinois at Chicago</u>

Phone: 1-312-413-4624

Website: University of Illinois at Urbana/Champaign

Phone: 1-217-244-1395

The Autism Program (TAP) is a network of resources for Autism Spectrum Disorders in Illinois. TAP provides the strategy and framework for Illinois to address the complex issues involved in diagnosis, treatment and research for the thousands of children in Illinois with ASD. TAP has developed an infrastructure to train, support, and coordinate the linkage of an informed provider network to help Illinois families. In addition to the above, TAP has numerous service centers, outreach centers, and collaborative partners. Information is available on the TAP website.

Birth to 5: Watch Me Thrive!

Watch Me Thrive webpage

Provides information about healthy child development, and developmental and behavioral screening among children.

National Center for Latinos with Disabilities

■ Phone: 1-800-532-3393

Provides free information about disability issues in Spanish.

National Lekotek Center

■ Phone: 1-800-366-7529

Provides information about and resources for children with special needs, including loaning educational toys.

Children with Special Health Needs Referral Information and Resources

Illinois Department of Human Services

Referral Information

Bureau of Disability Determination Services

Bureau of Disability Determination Services webpage

Phone: 1-800-843-6154TTY: 1-800-447-6404

Bureau of Home Services (Respite and HIV Programs)

Bureau of Home Services (Respite and HIV Programs) webpage

Phone: 1-800-843-6154TTY: 1-800-447-6404

Centers for Independent Living

Centers for Independent Living webpage

Phone/TTY: 1-217-782-9689 (Springfield)Phone/TTY: 1-312-814-4037 (Chicago)

Community Resources - Transition/STEP

Community Resources – Transition/STEP webpage

Phone: 1-217-785-7751TTY: 1-888-845-4143

Educational Services

Educational Services webpage

Phone: 1-217- 524-1379TTY: 1-888- 532-4146

Family and Community Services - Programs and Services

Family and Community Services – Programs and Services webpage

Phone: 1-800-843-6154TTY: 1-800-447-6404

Services for Persons who are Deaf or Hard of Hearing

Services for Persons who are Deaf or Hard of Hearing webpage

Phone: 1-800-843-6154TTY: 1-800-447-6404

Other

Referral Information

DSCC Regional Office Locator

DSCC Regional Office Locator webpage

Phone: 1-800-322-3722TTY: 1-217-785-4728

Illinois School for the Deaf (ISD)

Illinois School for the Deaf (ISD) website

■ Phone: 1-217-479-4200

Illinois School for the Visually Impaired (ISVI)

Illinois School for the Visually Impaired (ISVI) website

Phone: 1-800-919-5617TTY: 1-217-479-4415

Illinois Center for Rehabilitation and Education – Roosevelt (ICRE-R)

Illinois Center for Rehabilitation and Education – Roosevelt (ICRE-R) website

Phone: 1-312-433-3100TTY: 1-888-261-8561

Next Steps and Lekotec

Next Steps and Lekotec websitePhone: 1-217-525-6522

Procedure Codes Common to Healthy Kids Services Healthy Kids Program

These codes are for reference purposes only and do not replace or override current accepted billing practices and standards.

Procedure Description	Recommended CPT Code	
Well Child Visit		
EPSDT Well Child Visit	99381-99385 (new patient – allowed once for any provider seeing patient for the first time) 99391-99395 (established patient) (use appropriate CPT code for the medical service provided)	
Make Up Visit	Use appropriate Well Child Visit Code or Evaluation and Management Code – one inter- periodic visit is permitted per year	
Hearing		
Screening test, pure tone, air only	92551	
Pure tone audiometry (threshold); air only	92552	
Audiometry, air and bone	92553	
Tympanometry (impedance testing)	92567	
Otoacoustic emissions (OAE)	92558	
Auditory brainstem response (ABR)	92586	
Vision		
Visual function screening, automated or semi-automated, bilateral quantitative determination of visual acuity ocular alignment, color vision by pseudoisochromatic plates and field of vision (may include all or some screening of the determination(s) for contrast sensitivity, vision under glare) Screening test visual acuity quantitative, bilateral HOTV	99172 – Cannot be billed with 99393 or in addition to any other general ophthalmological service or an E&M code, per CPT guidelines. 99173	
Lea	99173	
Snellen	99173	
Ocular photoscreening with interpretation and report, bilateral	99174	

Lead Screening	
Blood Lead Analysis	83655
Epidemiology (used by health departments only)	T1029
Collection of venous blood (venipuncture)	36415 U1
Collection of capillary blood specimen	36416 U1
Blood Lead Testing System CLIA waived, Blood lead	83655 QW
testing system (whole blood)	

Immunization Resources

For locations of free immunization clinics:

■ CDPH 311 (in Chicago only)

1-312-746-6129

■ IDPH 1-217-785-1455

For clinical questions about vaccines:

CDC Informational Hotline
 1-800-CDC-INFO (1-800-232-4636)

■ CDPH 1-312-746-6088

1-312-746-6226

1-312-746-5382

■ IDPH 1-217-785-1455

For information about or to schedule the Care Van:

CDPH 1-312-746-6122IDPH 1-217-785-1455

To report a vaccine preventable disease:

CDPH 1-312-746-5901IDPH 1-217-785-1455

To report adverse effects of immunizations:

Vaccine Adverse Events Reporting System (VAERS) 1-800-822-7967

VFC Vaccines – Chicago 1-312-746-5382
 VFC Vaccines – IDPH 1-217-785-1455

For requirements for travel abroad:

■ Phone 1-877-FYI-TRIP (toll free)

Website www.cdc.gov/travel

Immunization related websites:

- Guidelines, Q&A www.cdc.gov/vaccines
- "Needle Tips" newsletter, hepatitis B information, patient education materials www.immunize.org
- Immunizations schedules (CDC) website

Vaccines for Children (VFC) Program

Participation in the VFC Program requires that the provider complete a Provider Enrollment Form and a Provider Profile Form.

Participation in the VFC Program for *Chicago* providers:

- Occurs through the Chicago VFC Program.
- For more information on how to enroll as a VFC Provider in Chicago
 - Phone: 1-312-746-6358
 - Participation in the VFC Program website

Participation in the Illinois VFC Program for providers in *Illinois* (outside the City of Chicago):

- Occurs through the Illinois Department of Public Health (IDPH)
- For more information on how to enroll to be a VFC Provider in Illinois (outside Chicago)
 - Phone: 1-217-785-1455 or 1-800-526-4372
 - Participation in the Illinois VFC Program for providers in Illinois (outside the City of Chicago) website
 - E-mail: dph.vaccines@illlinois.gov

Once the provider has submitted required enrollment forms, the Chicago VFC program meets in person with potential providers and physically inspects the vaccine storage appliance to determine adequacy. Once enrolled, providers are assigned an order frequency consistent with their forecasted volume of vaccines. This may mean that providers order monthly, bimonthly or quarterly. They do not receive three month shipments of vaccines as Illinois VFC providers do.

Once the provider has submitted required enrollment forms, IDPH will perform an enrollment visit at the practice to assure appropriate capacity for vaccine storage and handling and address required provider documentation. Based upon VFC-eligible patient population size, providers are advised on frequency for submitting orders. Each order includes full accountability for previously shipped vaccine. IDPH requires all Illinois VFC providers to document VFC vaccinations given into the Illinois Comprehensive Automated immunization Registry Exchange (I-CARE) system. All Illinois VFC orders and accountability reporting also are managed through I-CARE. Providers can input data manually or interface electronic medical records (EMRs) to I-CARE.

Information about I-CARE access

Phone: 1-800-526-4372Website: IDPH I-CARE

■ E-mail: <u>dph.icare@illinois.gov</u>

Providers may not charge for the cost of the childhood vaccine provided by the VFC Program. The provider may charge HFS for the administration of the vaccine to program participants. Providers enrolled in the VFC Program are supplied with ACIP recommended vaccines by IDPH or the Chicago Department of Public Health (CDPH) and are reimbursed by HFS with an administration fee. The amount charged to HFS for the administration of the vaccine should be the provider's usual and customary fee for administration of the vaccine (refer to Topic HK-202, Billing).

Providers report the immunization given to the All Kids participant by identifying each immunization provided, using the CPT-specific immunization code, (not the generic CPT code for the administration of an immunization).

While there is no additional payment for administration of a vaccine to providers serving managed care enrollees or to encounter rate clinics (e.g., FQHCs, RHCs, or ERCs) the detail regarding the specific vaccination defined by the CPT code must be reported on the encounter claim so that an accurate immunization history is recorded by HFS and is available to the child's PCP, parent/caretaker relative or guardian.

Transportation Assistance

Transportation is a covered service for an eligible All Kids participant (whose family income is under 200 percent of the federal poverty level) and if necessary, for an attendant, to or from a source of medically necessary care when a cost-free mode of transportation is not available or is not appropriate. Medically necessary care is defined as any medically necessary service covered under the Medical Assistance Program. Transportation is to the nearest, available, appropriate provider in the least expensive mode that meets the medical need of the participant.

An employee attendant is defined as a person, other than the driver, who is an employee of a Medicar, service car, or taxicab company. A non-employee attendant is defined as a family member or other individual who may accompany the participant when there is a medical need for an attendant.

An employee attendant or a non-employee attendant is a covered service when the mode of transportation is a Medicar or Service Car, or taxicab and the circumstances constitute a medical necessity. Transportation to and from a source of medically necessary care requires prior approval. Prior approval is not needed for emergency medical transportation.

HFS has a contractor to handle prior approval of transportation requests covered under the Non-Emergency Transportation Services Prior Approval Program (NETSPAP). This contractor does not provide transportation services under NETSPAP. Prior approval is required for all non-emergency medical transportation from the HFS contractor.

First Transit

Mail: 799 Roosevelt Rd

Bldg 4, Suite 200 Glen Ellyn, IL 60137

Provider (toll free) 1-866-503-9040 Fax: 1-630-873-1450 TTY: 1-630-873-1449

Participant (toll free): 1-866-725-0569

Website: http://www.netspap.com

The participant, medical provider or transportation provider may call to receive prior approval for single trips. Requests for standing orders must be made in writing to the HFS contractor and can be made by anyone for all services. The standing prior approval may be faxed to: 1-630-873-1450.

In order to be considered for reimbursement by HFS, non-emergency transportation services must be:

- Provided to or from a covered source of medically necessary care
- Provided by a transportation provider enrolled with HFS

- Prior approved by HFS' contractor
- To the nearest available medical provider that meets the participant's needs
- Provided in the least expensive mode that meets the participant's medical needs on the date of transport.

Prior Approval Process

The request for transportation prior authorization must be made, by calling toll-free:

Provider: 1-866-503-9040
Participant: 1-877-725-0569
TTY: 1-800-526-0844

8:00 a.m. to 5:00 p.m. - Monday through Friday (closed on State holidays)

- The request must be made to First Transit at least seven (7) business days (excluding weekends and holidays) prior to the trip
- When calling for a prior approval, the following information must be provided:
 - The participant's name, address and telephone number
 - Recipient Identification Number
 - The name, address, and telephone number of the medical provider
 - The date, time and reason for the appointment
 - Transportation needs of the participant
 - The name of the transportation provider
- The HFS contractor will review the request, may contact the medical provider for additional information and shall take one of the following actions:
 - If the request is approved, the approval will be posted in HFS' prior approval system and a request tracking number will be issued. Transportation for the participant may then be arranged. HFS will generate a Notice of Approval letter that contains information necessary to bill HFS for the service. To ensure accurate billing, the transportation provider must wait for the approval notice before submitting a bill to HFS. The transportation provider should bring errors on the Notice of Approval to the attention of HFS contractor.
 - If the request is denied, the denial will be posted in HFS' prior approval system along with the reason for the denial. HFS will generate a denial letter to the participant and the transportation provider.

If the child is enrolled in an MCO under contract with HFS, that MCO is required to approve, arrange and reimburse for the transportation to and from the source of medical care, if needed by its member. Prior approval from the MCO is not needed for emergency medical transportation. Contact the MCO for more information on how to arrange transportation to and from a source of medical care.

Weight Related Resources

- Weight-Related Clinical Care Tools and Education webpage
- Map of Weight-Related Community Resources in Illinois website
- Illinois Food and Nutrition Education Programs website
- Healthy Active Living for Families (Patients/Family) webpage
- Healthy Active Living for Families (Providers) webpage

Oral Health Resources

For assistance in finding a dentist for referral, contact:

DentaQuest of Illinois:

Provider service
 Customer service and referrals for clients
 Website
 1-888-281-2076
 1-888-286-2447
 www.dentaquest.com

Oral Health Resources:

 Bright Smiles from Birth: An Oral Health Education and Technical Assistance Program webpage

o Phone: 1-312-733-1026

- American Academy of Pediatrics Oral Health Initiative website
- American Academy of Pediatric Dentists website
- American Dental Association website
- National Maternal and Child Oral Health Resource Center website
- National Institute of Dental and Craniofacial Research website

Homeless Resources

DHS Housing Programs/Services website

Illinois State Board of Education

- Each school district, in accordance with the federal McKinney-Vento Homeless Assistance Act and Illinois law, must have identified a coordinator for services of students who are homeless.
- Illinois State Board of Education webpage

Statewide Provider Database (SPD) Informational Brochure [pdf]

- The SPD is an online resource for service and program information throughout Illinois. This online database includes comprehensive information on services throughout Illinois covering mental health, substance abuse, parenting, domestic violence, early childhood, health clinics, non-clinical services (e.g., after-school, recreational programs, tutoring, mentoring, vocational programs), and homelessness resources.
- Contact Eileen Reilly (Email: Eileen.Reilly@illinois.gov) to get access to the SPD

Statewide Provider Database Login website

- Contact Eileen Reilly (Email: Eileen.Reilly@illinois.gov) to get access to the SPD
- Website: https://illinoisoutcomes.dcfs.illinois.gov/

Ounce of Prevention Birth to Five Program Inventory

- Program inventory of initiatives serving children under age five and their families.
- Website: http://www.theounce.org/

National Health Care for the Homeless Council

- Informational website describing the interaction of inadequate housing and poor health. Includes resources for clinicians and administrators providing educational materials to support provision of care to those who are homeless.
- Website: http://www.nhchc.org/

HFS Form 724



State of Illinois Department of Healthcare and Family Services

Screening, Assessment and Evaluation Tool Approval Request Form

Under the authority of the *Handbook for Providers of Healthy Kids Services* sections HK203.5.4, HK203.9.1 and HK203.9.3, Providers may request the Illinois Department of Healthcare and Family Services (HFS) for additions to the list of approved developmental screening and evaluation tools, health risk assessment tools, and perinatal depression screening tools to be recognized by the Department for payment. The Provider must document that an instrument meets the following criteria:

- 1) The tool is listed in most recent edition of the Mental Measurements Yearbook;
- 2) The tool is nationally distributed;
- 3) The tool is age appropriate;
- 4) The tool has been formally validated; and
- 5) The tool is individually administered.

The tool must be approved for use by HFS before it can be claimed for reimbursement. Use this form to submit screening, assessment and evaluation tools for review and approval for reimbursement by HFS.

It is the Provider's responsibility to present proof of the above criteria to HFS. The Mental Measurements Yearbook can be found at the Early Childhood Intervention Clearinghouse, many local libraries, and by visiting the Website at www.unl.edu/buros. There is a cost to access some of the materials found on this Website. Any cost is the responsibility of the Provider. HFS reserves the right to waive any or all of the above criteria for cause (e.g., legislative mandate, programmatic requirement, federal regulations).

For consideration, answer the following questions and provide the requested information.

ing Request:		
State _	:	Zip Code
	Fax Number:	
ourpose of the tool:		
you are requesting HFS approve the	e tool:	
	Statestate	Fax Number:

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What is the cost to purchase the tool?	
In your submission, include a copy of the relevant pages. No □ a. In your submission, include a copy of the relevant pages.	
Is the tool nationally distributed? Yes ☐ No ☐ a. Specify the publisher and distributor of the materials:	
Publisher	
Distributor	
What ages are covered by the tool?	
4. Are there any other published restrictions or limitations associated with the tool?	
5. Is the tool formally validated? Yes ☐ No ☐	
 a. Provide a list of references below showing the tool is validated. b. In your submission, provide a copy of each article cited. 	
Reference:	
Reference:	_
Reference:	_
6. Is the tool individually administered? Yes ☐ No ☐	
7. Is the tool being submitted via the Illinois Department of Human Services (DHS) Early Intervention (EI) program? Yes ☐ No ☐	
8. Is the tool endorsed for use by a state agency or a particular interested group? Yes \(\subseteq \) No \(\subseteq \)	
If yes, please specify:	
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Send this completed form with the requested background information (see above) to:
Mail: SAE Committee Bureau of Quality Management Illinois Department of Healthcare and Family Services 201 S. Grand Avenue, 2 nd Floor Springfield, IL 62763
E-mail: HFS.ChildHealth@illinois.gov
Conflict of Interest Statement The potential for conflicts of interest exists when an individual has the ability to control or influence the content of a tool(s) submitted for approval and has a financial relationship with a commercial interest* in the products or services of which are pertinent to the content of the tool(s) submitted for approval. Anyone who is in a position to influence or control the content of a tool submitted for approval must disclose any financial relationship or other commercial relationship related to the tool(s) submitted. Financial or other relationship may include, but is not limited to such things as grants or research support, employee, consultant, major stockholder, etc. that has occurred for any dollar amount over the past 12 months. The intent of disclosure is not to prevent a Provider with a financial or other relationship from making a request, but rather to resolve any conflicts prior to the review of the tool(s) submitted.
(1) Each person and/or entity with direct or indirect ownership or control interest in the requesting Provider or an immediate family member, including spouse or partner, have no financial relationship(s) relevant to the content of this submission and the tool recommended for approval.
(2) A person and/or entity with direct or indirect ownership or control interest in the requesting Provider, or an immediate family member, including spouse or partner, have a financial relationship with a commercial interest or have control or influence over the content of the tool(s) submitted that could be perceived as a real or apparent conflict of interest within the context of this submission and the tool(s) recommended for approval.
(Provide specific information below. If needed, continue on another sheet.)
The signature of the individual completing this form and Conflict of Interest Statement attests to the accuracy of the information given above.
Signature (Required) Date
*Commercial interest is any entity producing, marketing, reselling, or distributing goods or services consumed by or used with clients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes goods or services consumed by or used with clients.

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